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THE CONCEPTS OF "MEANING" AND "CAUSE" IN PSYCHODYNAMICS [1]

JOHN C. WHITEHORN, BALTIMORE, MD.

There is much that is irrational in the behavior of neurotic and psychotic patients which had been considered in the descriptive age of psychiatry as psychologically nonunderstandable and therefore insignificant, except as evidence of disease. In large part the apparently irrational has been found intelligible and personally meaningful *as reaction pattern,* in the modern, biologically oriented frame of reference of personality functions, particularly through the aid of the facts brought to light by psychoanalytic study of the unconscious. One may say that conceptual means have been found to "unscrew the inscrutable." We appreciate now that even irrational symptoms have personal meanings (for the patient although he may not tell us or even know it, as well as to the psychiatrist). Yet these forms of behavior presumably also have causes; and meanings and causes are not the same.

Some psychiatrists profess a belief in absolute psychic determinism as a scientific dogma, but this is an affirmation of metapsychological faith, not a statement of fact. The hypothesis of psychogenesis is not the only reason for the close scrutiny of a patient's attitudes and the searching of issues at stake in his reaction to his situation. For the strategy of psychotherapy there is much practical value in recognizing the *meaning* of reactions, even though causal explanation be lacking. In modern psychodynamic psychiatry, as distinguished from the preceding stage of descriptive psychiatry, one of the main principles is to conduct an individualized study of each patient adequate to point up the main recurrent theme or issue of dissatisfaction and conflict, to assess the individual's currently unused potentialities for dealing with this issue and to evoke a well-founded and self-assured mode of resolving the issue more satisfactorily.

Some persons show perspicacity in discerning the themes or issues which make understandable much psychopathology that is otherwise apparently irrational. Such perspicacity can be cultivated and made useful for psychotherapy. Much of one's supervisory assistance to trainees consists in helping them search and sift their facts and sharpen their observations about a patient to gain a well-justified formulation of the meaningfulness of a situation for a patient and the relevance of his reaction thereto. The catch-word "psychogenesis" has become something of an impediment in this task. The perception of an issue in a patient's life, which could clarify the meaningfulness of his reaction, is not infrequently misconstrued as if it were the discovery of *the cause* of the patient's illness. Some young doctors are made foolishly happy thereby, feeling that they have "explained the illness"; some others, more discerning, perceive that the explanation is not complete, and so, obsessed with the fancied necessity for getting a complete psychogenetic explanation as a preliminary to therapy, they frantically attack the patient again and again, picking him to shreds in the ingenious effort to ferret out the true "cause," while neglecting the large strategic possibilities of aid to the patient which might be rendered through the appreciation of "meanings" implied in current and past experience.

I wish to make clear that it is not my purpose in this discussion to deny the validity of the psychogenetic concept. I believe that, among the many facts whose combination determines the development of a neurotic or psychotic condition, psychological experiences are of critical importance. One could even say, *in some instances,* that *single traumatic events* are of crucial importance, as in some of the combat neuroses. In general, however, we have probably all come to the realization that *clinical study seldom reveals a single crucial traumatic event as the specific cause of a neurosis.* Most commonly one finds anamnestically, a wealth of symptomatic anecdotes, *expressive* of the pathological attitude, rather than *causative* of it.

[1] Read at the 103d annual meeting of The American Psychiatric Association, New York, N. Y., May 19-23, 1947.

It is also commonly true, in an intensively studied and treated case, that many small items come to light indicative of a general pressure of many psychogenetic influences which have combined in shaping one's neurotic attitudes. It is possible, thus, in a fair proportion of thoroughly studied cases, to construct a fairly plausible but rather complex etiological hypothesis for the individual case.

The plausible etiological hypothesis, finally elaborated, may, however, be of considerably less strategic importance in therapy than the mutual understanding, reached much earlier, by which physician and patient both come to understand the meaning of some of the patient's neurotic behavior in terms of emotional need, rather than in terms of historical cause and effect. To arrive at a mutual understanding of the theme of a repetitive pattern may provide at once an opportunity for a "corrective emotional experience" or an "attitudinal interaction," setting into motion powerful therapeutic impulses. Some physicians are disposed, however, by personality and by doctrine, to disregard such opportunities to deal with meaning, in an obsessive insistence upon a routine continuation of the search for *the cause*. In the long run, there is great scientific potentiality in this obsessive search for specific etiology. In individual instances, however, the particular patient does not always benefit. The patient may thereby suffer loss of time, loss of rapport, and loss of a helpful focus for his own efforts. It is important in treating the individual patient not to miss the opportunities for mutual understanding of a meaningful theme, out of a scientific zeal to get all the details pinned down rigidly for an etiological hypothesis. Particularly if the patient has schizoid tendencies, such obsessive insistence provides one of the quickest and surest ways of losing a therapeutic relationship.

Personal experiences color professional thinking. My own earlier psychotherapeutic experiments were with psychotic patients, who, in comparison with neurotic patients, usually require a more personal support and more mature appreciation from the therapist, as encouragement to their shattered egos. One has many opportunities to notice in the early phases of the psychotic patient's progress toward recovery that the patient does begin by making tentative and hesitating steps of his own. Without some spontaneity, the therapist is stymied. How to elicit and encourage spontaneity in a constructive direction is the most difficult technical problem, and in this task the therapist's grasp of the potential meaningfulness of the life-situation and the meaningfulness of the patient's reaction does give opportunity for helpfulness at a time before one has been able to get from the patient sufficient evidence to form a valid etiological hypothesis. The following incident may serve as an example:

A manic patient, Robert S., 50 years old, a business executive, upon being addressed by a certain doctor as "Mr. S.", repeatedly requested that he be called just "Bob." When the doctor inquired into the reason for his request the patient replied, "You are my superior—you are No. 1." The doctor then questioningly repeated the word "superior," while raising an eyebrow at the same time. This resulted in an outburst of seemingly incoherent talk, which included the sentence, "Well, okay, you are not my superior, so you may call me 'Mr. S.'" This little episode helped the doctor considerably to understand the patient's need in his relationship with him, and with other people as well. He was a proud, prestige-oriented person who resented being dependent and attempted to minimize his dependence on the doctor by caricaturing it in a way which is so typical of the manic patient.

A discerning comparison of the patient's attitudes in the current situation, with his attitudes during his periods of better previous functioning, grows naturally out of this interest in issues and attitudes (that is to say, meanings), whereas a physician obsessed with a thirst for discovering "the cause," tends to neglect the therapeutically helpful review of the patient's best period, and to focus exclusively on the traumatic and the pathological.

These matters mark out, however, differences of emphasis rather than completely different principles in the psychotherapy of the psychoses and of the neuroses. In both there is great importance in timing the steps of therapy to fit the need and the mood of the patient at a given time. In psychother-

apeutic strategy, when one bears in mind the meaning or theme of the patient's pathological reaction, there are opportunities to evoke memories and attitudes constructively useful in relation to this meaning, but such strategic opportunities will be missed if the psychiatrist is continually obsessed with the necessity to pin down the cause as the preliminary to psychotherapy.

Experience in the psychotherapy of neurotic patients makes one very familiar with the patient who has cooperated nicely with a psychiatrist's efforts to explore early memories and emotional traumata, and who has arrived at a fairly neat psychogenetic formulation, but without benefit in the form of personality growth or even relief of symptoms. The intellectual insight, or pseudo-insight, of such patients is a dubious benefit. It is not infrequently a considerable handicap to more effective therapy. Such experiences demonstrate the fallacy of the glib phrase: "Find the psychogenetic cause and eliminate it." As Franz Alexander has expressed it, the essence of psychotherapy is the "corrective emotional experience." The therapist has a considerably greater chance of helping his patient to achieve a "corrective emotional experience" if he directs his attention to the indications of the "meanings" implied in the patient's experiences, current and past, rather than focussing merely on indications of potential "causes."

Since the psychoanalytic school of thought has particularly emphasized psychic determinism and the etiological focus of therapy, it would be only natural that one would expect to find among psychoanalysts more than among other psychiatrists those who are, in a doctrinaire way, obsessed with the necessity to discover the psychic etiology as preliminary to psychotherapy. It is my impression, however, that this doctrinaire attitude is more characteristic of the psychoanalyst of limited experience. There is still, however, a persisting attitude in psychoanalysis, carried over from the phase of overemphasis "on the intellectual understanding of the past that made psychoanalytic treatment almost synonymous with genetic research." [2]

[2] P. 20. Alexander, Franz, French, T. M., et al. Psychoanalytic Therapy, The Roland Press, New York, 1946.

For one, concerned as I am, for purposes of psychotherapeutic strategy, to place much emphasis upon the *meaningfulness* of neurotic or psychotic reactions, in terms of the themes or issues involved in those reactions, it would be somewhat ungracious to appear in any way to make unduly critical remarks about psychoanalysis, just because some analysts have given too exclusive an emphasis to doctrines of etiology. We owe to psychoanalysis, more than to any other method or school of psychiatric study, the appreciation of meaningful issues in neurotic reactions. Historically, this has also been accompanied by many valuable etiological studies. The principal purpose of my discussion today has been, not to deplore the interest in "cause," but rather to deplore, and to seek to correct, the haziness of thinking which tends to obscure the distinction between "meaning" and "cause," so important for psychotherapeutic strategy.

Etiological research must of course continue, and it has better prospects of success through the increasing understanding of the meaningfulness of symptoms. Meaning and cause are not mutually contradictory; but neither are they synonymous. The understanding and practice of psychotherapy will be improved by the more general recognition of this distinction.

At the present time there are two special reasons for emphasizing the therapeutic implications of the distinction between meaning and cause.

One reason lies in public misunderstanding. Many persons have gotten from the movies, novels, and Sunday papers a mistakenly simplified notion that psychiatric salvation lies wholly in recapturing some specific forgotten memory and thereby finding and removing "the cause" of emotional ill health. The simplicity of this concept and the implications of painless magical therapy give it a special appeal to neurotic patients; and a special investment of time, effort, and tactful education is now often required to circumvent this romantic expectation. The psychotherapist needs to keep in his own mind a fairly clear-cut distinction between cause and meaning in order to avoid the pitfalls set by the patient's misled expectations.

A clear distinction also helps to avoid aimless quibbling with the patient about this issue.

The other main reason for emphasizing at this time the distinction between "cause" and "meaning" of symptoms lies in the overcrowded condition in most of the good institutions training young psychiatrists. Increased numbers in training dilute the advisory supervision and favor a tendency toward didactic patterns. The bright young trainee discovers that, in seminar and staff conference, interest and approval are aroused by case presentations well padded with so-called "etiological" probings in the direction of early memories and traumatic episodes. The techniques of personality dissection are easier and more spectacular than those of plastic reconstruction. If we fail to keep the young psychiatrist clearly oriented to current issues and attitudes in the patient's life, we are likely to develop a crop of probe-pushers, clever in case presentations but not very competent in actual management and therapy of real patients.

The present situation has seemed to me, therefore, to require some clarification of concepts along the lines of the distinction herein made between "meaning" and "cause."

SOVIET PSYCHIATRY IN THE POST WAR PERIOD[1]

PROF. V. A. GILYAROVSKI

Member of the Academy of Medical Science of the U. S. S. R.

Soviet psychiatry is passing through a significant period of its development. The end of the victorious war gives it an opportunity to resume peacetime progress. "The problem of science is to anticipate and to act," said Claude Bernard. It is a question of scientific foresight based on the laws governing the course of its development. With reference to psychiatry this means the necessity of analyzing everything pertaining to morbidity, in order that the essential measures may be taken for combating it and for strengthening the mental health of the population.

During the war in the U.S.S.R. there was no increase in the number of schizophrenic illnesses and of endogenous psychoses generally, but there were somewhat more reactive forms. One should consider, however, that the influence of unfavorable factors connected with the war will continue for some time after its cessation. Psychic trauma often leaves in the nervous system changes which maintain for a long time their morbid potentiality. While not at once giving rise to definite manifestations in the neuropsychic sphere, they may later lead to pathological phenomena, particularly if other etiological factors are added. The same is true of concussion.

But it is necessary to keep in view the fact that factors of war cannot be examined only in the sense of detrimental influences on neuropsychic health. In some cases one may speak of the attenuation and suppression of morbid manifestations, if only temporarily. The behavior of schizophrenics, for example, in many cases changed to better adjustment in the community and interest in work. The general drive for defense work may mobilize more healthy aspects in the psyche of the mentally ill, giving them a chance to participate in the group. With the end of the war and the cessation of the stimulating situation, the mobilizing influence is falling off and what was suppressed is brought to light again, sometimes with greater force than previously.

Past experience indicates that, after great wars, as a rule there has been an increase in the number of nervous and mental disorders. The cause of this has consisted in a deterioration of physical health and reduced resistance to external noxæ; a great rôle is also played by the spread of infectious diseases, which in the past was a rule in war and in the postwar period. Factors of a psychological order are of exceptional importance. The increase in morbidity in the period 1914 to 1918 depended on all these factors, especially on the unpopularity of the war, the consciousness of the masses of its uselessness. In the recent war an increase in psychic morbidity did not take place; but this fact does not give Soviet doctors the right to self-complacency in the assurance that it will be so in the future, even if no measures are taken at all. Four years of strenuous work under difficult conditions with nervous strain and psychic trauma could not pass without a trace. If no increase in psychoses occurred, this does not exclude the possibility of changes in the neuropsychic sphere, not emerging in the form of definite illnesses but presenting signs of certain disorders in the organism susceptible of becoming definite illness under unfavorable conditions. In this sense one must be very careful of signs indicating even small changes in morbidity. The experience of past wars compels one to keep neurotic conditions in view particularly; analysis of available data reveals much of interest along other lines.

The Psychiatric Institute of the Academy of Medicine has analyzed data from Moscow psychiatric hospitals and clinics for a period of almost 20 years. As regards neuroses and reactive conditions, percentages beginning with the year 1931 continued on an approximately even level: 16, 15, 15, 14, 16, 17, 18.

[1] A brief abstract of this paper was printed in the *American Review of Soviet Medicine*, Feb. 1947. The Editor, Dr. Jacob Heiman, kindly supplied the full Russian text and authorized its use.

The translation was made in the Science Library of the Institute of Living, Hartford, Conn., through the kindness of the director, Dr. C. C. Burlingame, and is presented herewith.—Ed.

In the year 1941 a significant decrease is noted—13.5%, undoubtedly owing to the suppression of morbid phenomena and diversion of attention to war events. Some increase was observed in 1944.

The writer put forward the idea of the nervous demobilization syndrome, the severe picture of nervousness showing itself not immediately, under the influence of traumatic psychological factors, but later, when there is a change for the better and the situation does not require the former strain. Such pictures could be observed during the war, but more often they should occur after it as late nervous reactions.

This does not mean, however, that one should be mindful only of the increase in nervous reactions and psychogenic reactions in the strict sense, for analysis of the dynamics of morbidity in time of war shows that the change is noticeable in other groups as well.

There are very interesting data referring to general paralysis and cerebral syphilis. It is not surprising that a gradual decline has occurred in primary consultations for general paralysis until recently. Figures with regard to cerebral syphilis continue at the same level except for a slight increase in the last years of the war. Wartime conditions were rather unfavorable for treatment and of course more attention should be paid to this now. With regard to citizens in places formerly under German occupation, their greater chance of infection with this illness must be kept in mind.

If one is mindful of the dynamics of those morbid processes which require more ambulatory than hospital care, one must pay more attention to the wartime increase in vascular diseases, arteriosclerosis, and hypertension. This is observed both in hospitals and clinics. Comparative statistics by year are convincing in this respect. The increased morbidity due to sclerosis of the cerebral blood vessels is sharply distinguished against the background of increase in organic forms. First of all one is impressed by the almost complete parallelism of the curves, reflecting the dynamics of cerebral arteriosclerosis and organic diseases. As concerns the first, the figure holds approximately at the same level, between 3% and 4%, in the interval 1930-1940. A significant rise is observed only with the year 1942. A still more significant increase is shown in statistics from hospitals—2.6% in 1937, 5.6% in 1944. Hospitals, of course, deal with the more severe cases, whereas clinics reflect the milder morbidity.

For examining more thoroughly the question of the dynamics and causes of the increase in illnesses, it was considered interesting to ascertain the corresponding data in general hospitals. In every psychosis, endogenous included, much of the morbid phenomena has a somatic root. Study of the somatic illnesses from the point of view of psychic reactions may assist in determining the structure of psychoses and in distinguishing somatic components in the complicated picture. On the other hand, if the study of lighter forms of the same illnesses in clinics, as compared with hospital cases, promises greater success for determining the pathogenesis, this is still more true as regards patients in the same groups in general hospitals. Here the connection of illnesses with general conditions as a whole, and the dependence of psychic changes on the somatic, may be established even more exactly. Data from general hospitals make it possible to demonstrate interesting dynamics, correlating in many respects with data of separate groups of patients in psychiatric institutions. And here particularly one observed a significant increase in cardiovascular disorders, generally arteriosclerosis and cardiosclerosis. At the same time it is hardly conceivable that it is a question of new diseases; under the influence of nervous, somatic, and neurovegetative strain, deficiencies become apparent which were formerly well compensated and which may be compensated even now.

Common to war dynamics and to illnesses of both the somatic and psychiatric series are changes in the vegetative nervous system in the direction of greater excitability. In work with neurotic conditions we always kept in mind the fact that under normal conditions, in a stable, purposeful individual psychiatrically speaking, the reaction to psychic trauma manifests itself, not in depression, tears, and behavior characteristic of the hysterical attack, but chiefly in the somatic and neurovegetative domain. Not infrequently

there arise in those conditions disorders which are apparently somatic but depend on disturbances of neurovegetative regulation rather than on visceral changes.

One may maintain that psychic morbidity is a derivative of general morbidity both in the sense of degree of diffusion and of clinical characteristics.

On good grounds one may say that the more or less express weakening of somatic health, the disorder of vegetative balance weakening neuropsychic stability and facilitating the development of disorders in the neuropsychic sphere, were a general phenomenon and should be considered as the direct consequence of the war and as affording an indication of the orientation which medico-prophylactic work should follow.

The future belongs to children, adolescents, and the young generation in general, a fact which is taken into account by the welfare organizations, the more so because of certain disquieting signs in their health which require particular consideration. These signs bespeak the necessity of centering attention on children, adolescents, and particularly workers in industry. Naturally university students should not be forgotten. Thanks to the enthusiasm characteristic of youth they overcame the greatest of difficulties without any disruption of their neuropsychic stability. But some traces of the shocks they endured remain, which might under unfavorable circumstances produce morbid changes. The Soviet Health Department plans measures also lest young people pay in the future for the fact that due regard was not shown for their somatic health at the proper time and that favorable conditions were not created for their life and work. Psychiatrists must point out that, in both medical and social organizations, special consideration should be given all adolescents and young people, both male and female, who formerly took part in the great war.

If one has the age index in mind, one should contemplate another aspect which for various reasons demands consideration in planning medico-prophylactic work. We have in mind people 45-55 years old. At this age a man has come to acquire great experience, knowledge, and occupational skill in one calling or another. In the masses, he is not only a qualified worker in such and such a branch but also head of a larger or smaller group. With his help, chiefly, the training of new personnel from the young generation is achieved. In men at this time of life health is on the decline. Not without reason have the French created the term, "l'homme de la cinquantaine."

At this age there begins not only sclerosis of the cardiovascular system as the expression of definite aging, but also physiological changes with considerable increase of pathological processes. We spoke above about the increase in vascular disorders during the war, and this has particular reference to this age. In such cases, one must not lose sight of the fact that these are people who have experienced 2 or even 3 wars and have participated in the struggle against fascism, if not at the front, then in defense work at the rear.

A special postwar problem of great state importance is the problem of veterans of the great war. The achievements of Soviet psychiatrists in the field of traumatic psychoses have created a good theoretical basis for the resolution of practical questions of treatment. The investigations of Gurevich, Shmaryana, and Golant have contributed much toward greater knowledge of clinical aspects of traumatic psychoses, the differentiation of various forms, and the localization of the greatest damage in individual cases. Gilyarovski has paid great attention to the course and remote consequences of trauma. Rochlin and Sereiski have established new facts concerning traumatic epilepsy. The Psychiatric Institute of the Academy of Medicine, with Gilyarovski, Remezova, and Lukomski, have devoted attention to the psychic reactions in surgical and wounded patients and have shown that an inventory of the psychic aspect is of utmost significance for the treatment of the basic illness. Soviet investigators, both those belonging to the Psychiatric Institute of the Academy of Medicine and others—Zalkind, Goldovskaya—are compiling a new chapter in the psychiatry of the neuropsychic changes in long-standing extracranial wounds and also in amputees. Psychiatrists have utilized physiological factors in reestablishing nervous functions in the treatment of the traumatic psychoses.

Soviet psychiatrists, however, do not think that all theoretical questions, clinical and pathogenetic, in this province are already solved. The postwar period provides the possibility of utilizing in full measure principles whose importance has been particularly put forward in recent times—notably the follow-up study. Study of the dynamics of traumatic psychosis, with regard particularly to the remote consequences, will occupy a prominent place in general psychiatric work of the postwar period.

A more accurate definition of traumatic encephalopathy, its delimitations and legal aspects, is among the questions requiring attention. The application of more delicate methods of investigation allows the discovery, sometimes, of mild changes which seem to be a consequence of skull trauma, but they remain purely local signs which do not give one the right to recognize a psychiatric condition, with all its practical inferences. Here we see the danger of generalizing the idea of illness. With the end of the war the question of exact diagnosis and evaluation has not lost its importance, even if one has in mind the physical examination of recruits for the army; but the question has acquired particular importance in the field of pre-employment medical examination. A noncritical attitude as to the importance of "microsymptoms" and their overestimation may lead even a legal psychiatrist into error.

Experience obtained during the war with the study of the sequelæ of head trauma should be used in relation to trauma in time of peace. Here one should have in view trauma in transportation and in industry. For various reasons adolescents are especially often involved, and in recent times it has been precisely they who have been implicated in industry.

On the prophylactic side, one should also direct attention to trauma in the large towns as the result of the unusual development of street traffic and different kinds of transportation. For evident reasons, children are particularly often the victims. The number of accidents increases together with the age of the children, in other words, with the increase in activities and mobility. Obviously, boys are most often exposed. In regard to consequences of skull trauma in children, as compared with adults, there stands out most the feature of pathological personality development in the sense of excitability and egoism with manifestations of antisocial propensities.

Aiming at the liquidation of the consequences of war, psychiatrists are not overlooking two other groups of people. The first is that of demobilized veterans of the Red Army. If they are discharged formally as free from illness, this does not mean that they do not have health deficiencies, particularly when it is a question of older age groups, of people who have endured all the burdens of the war. In a certain portion of cases, although they do not have definite illness, they do have the seeds of it demanding treatment which could not be carried out at all completely before demobilization. In a group of cases it may be a question of preinvalidism, of morbid phenomena bordering on genuine invalidism. The importance of carrying on sustained work in clinics for all veterans is unquestionable.

The other group, a very numerous one, requiring attention is that of women—mothers and housewives. They remained behind after mobilization of their husbands and sons; entirely alone they accomplished heroic work in caring for small children under difficult conditions of wartime and they have the right to attention to their neuropsychic health.

The direction in which psychiatric work should go in the postwar period may be considered essentially clear; but undoubtedly it should be centralized, offer internal unity, be guided by one and the same principle.

Psychiatry in its development has passed through several periods and each of them is characterized by some principle. There was the period of custodial psychiatry which preceded therapeutic psychiatry. A new stage showed the prophylactic orientation, occurring after World War I together with the October Revolution. Should it be confined to previous principles or does it need something new? In order rightly to answer this question one must bear in mind the epoch in which we live and the tasks that arise at the present time. The next period will be crowded with creative work on all

sides of life. Therefore restoration alone is insufficient therapy and something more is required. Physicians have created for themselves the notion of euthanasia, painless, "happy" death. Mankind was designed not to die a happy death, but to live happily. Life itself is a creation and happiness is the satisfaction derived from creation. Instead of euthanasia, therefore, one would do better to speak of eubiosis, happy life in creative activity, as the goal toward which to strive. This is in conformity with one of the points of the five-year plan of the Ministry of Health of the U.S.S.R.—an increase in the duration of life. If one ponders this carefully, it is plain that the entire program is for action. Apart from the above-enumerated measures for the improvement of sanitary conditions on a nation-wide scale, factors depending on people themselves do not have a small significance. By neglect of one's health, inability to organize one's life and work, one not infrequently shortens one's own life, and the life of others as well, by unwillingness and incapacity to consider their interests.

Here again one should recall the rôle of psychic factors, the meaning of which was so vividly exposed in the experience of the great war. Ambroise Paré said that happy people are ill less and live longer. The gay temperament may be not only of a constitutional nature but also the result of a better somatic state, favorable conditions of life and work, and satisfaction in the latter. To the creation of such conditions for creative work, psychoprophylactic effort should also be aimed. One needs to understand the idea of creative work in its broadest possible significance. It embraces the work of school children, the work of university students, as well as work in industry and general participation in constructive work in one field or another. Before Soviet physicians stands the problem of elaborating a mental hygiene under new conditions.

FIRST YEAR ANALYSIS OF VETERANS TREATED IN A MENTAL HYGIENE CLINIC OF THE VETERANS ADMINISTRATON[1]

S. FUTTERMAN, M. D., F. J. KIRKNER, PH. D., AND MORTIMER M. MEYER, PH. D.
Los Angeles, Cal.

The Los Angeles Mental Hygiene Clinic of the Veterans Administration had its beginning on June 26, 1945, and is the first clinic of its kind in the Veterans Administration; others are now in operation in strategic centers with still more to follow. This is an outpatient clinic for treatment of the service connected emotional casualties of World War II. It has the responsibility for the entire outpatient neuropsychiatric service in the Los Angeles Regional Office. Its purposes are to provide early treatment, while there are elements of anxiety present and the symptoms are reversible, and before the anxiety becomes too well channelized into somatic symptoms with too much secondary gain and intractability, and when psychotherapy is likely to be most effective; to guide the severely mentally ill into suitable vocations and avocations; and to alleviate pressures from their environment and in this way prevent repetitive and prolonged hospitalization. In a long range program the impact of such clinics as this should be felt in combating neuropsychiatric illness and the promotion of mental health.

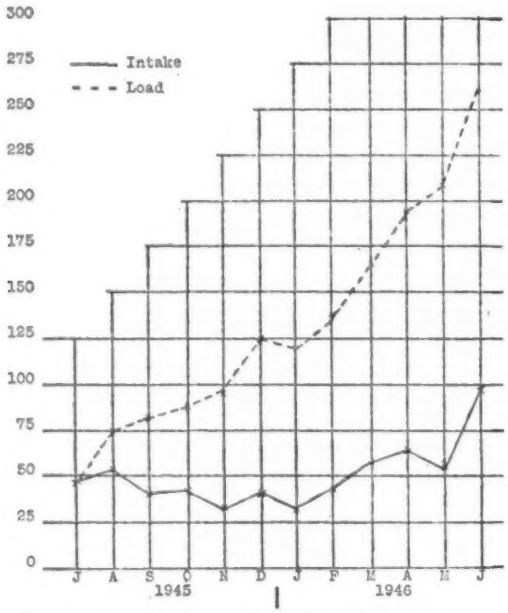
It is probable that the intake load will level off while the treatment load will continue to mount because of the time required even for a short term individual psychotherapy which is the predominant method of therapy. Group therapy, the various drug therapies and hypnosis are also used in an adjuvant capacity. The staff includes psychiatrists, psychologists and psychiatric social workers in the ratio of 1 : 1 : 2.

Since the beginning of the fall semester of 1945, the clinic has had in training psychiatric social workers from the University of Southern California, and from the spring semester of 1946, psychology students from the University of California and the University of Southern California. Since the fall of 1946 the training program includes psychiatrists, psychologists and psychiatric social workers in conjunction with the local universities.

Referrals are made from the various Veterans Administration facilities, from community social agencies, veterans service organizations and educational institutions. The patient's first clinic contact is with the receptionist, who makes an appointment for him with the psychiatric social worker. The psychiatric social worker takes the initial interview to ascertain the patient's problem and to prepare him for treatment. The chief psychiatrist is responsible for assignment of all cases. Treatment staff conferences are held at regular intervals to point up our methods which vary with the patient.

Since the clinic opened, data have been accumulated on a sample of 493 cases. There is a sampling of 178 cases from June 26, 1945 through December 31, 1945 and a sampling of 315 cases from January 1, 1946 through June 30, 1946. From here on these samplings will be referred to as "full year," "first half" and "second half," respectively. A form was prepared and the data were taken at intake and at the closure of the case. These data represent various kinds of information such as age, marital status, etc., which is recorded in the claims folder containing the medical record of the patient, as well as his attitudes when he appears at the clinic. In some tables the total clinic group is shown and, in addition, a psychoneurotic group. This psychoneurotic group has been segregated on the basis of the army diagnosis of psychoneurosis at the time of discharge although we may have found it necessary in some cases to change the diagnosis. This segregation was made so that we might compare our data to comparable data of army discharges of enlisted men for psychoneuroses.

[1] Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the authors.



GRAPH A.—Intake and load. (From June 26, 1945, through June 30, 1946.)

charges to our clinic cases of psychoneuroses. This is particularly in evidence for the age group of 20 and under, as shown in Table 1. In comparable samples for the clinics and the army discharges for psychoneurosis, it is shown that we have only 26.9% of those 24 years of age and younger, while the Army discharged 40.5% in this age group. A part of this age shift into older groupings may be due to the length of time out of service, since 41.2% of the patients, as shown in Table 10, were out of the service a year or more before they sought treatment. It is interesting to observe that the largest percentage for psychoneurotic cases in the clinic is 33.5 for 25-29 age group while the largest percentage for the total clinic is 38.3 in the 20-24 age group. The table further indicates that the psychoneurotic is likely to come for treatment at a later age than those in *general* in other neuropsychiatric diagnostic categories.

TABLE 1

AGE DISTRIBUTION COMPARED WITH ARMY NP DISCHARGES AND TOTAL POPULATION

	Clinic		Army(2)	
Age	Total Percent	Psychoneuroses * Percent	NP discharges Percent	Total population Percent
Under 20 years	1.1	0.7	7.9	11.5
20-24 years	38.3	26.2	32.6	41.9
25-29 years	25.7	33.5	25.7	25.5
30-34 years	19.1	25.5	20.6	13.5
35 years and over	15.8	14.1	13.2	7.6
	100.0	100.0	100.0	100.0

* Army only, excluding commissioned officers.

DATA

Branch of Service.—Cases have been accepted from four branches of the service—74.6% from the Army, 20.3% from the Navy, 3.9% from the Marine Corps, and 1.1% from the Coast Guard.

In comparison with the relative strength of the Army and Navy at the 1945 peak(1), these figures point to a proportionately larger number of veterans from the Army than from the Navy and may reflect the more careful selection of naval personnel.

Age.—For the most part there is a shifting to older age groups from the total army population to the army psychoneurotic discharges to our clinic cases of psychoneuroses. This is particularly in evidence for the age group of 20 and under, as shown in Table 1. In comparable samples for the clinics and the army discharges for psychoneurosis, it is shown that we have only 26.9% of those 24 years of age and younger, while the Army discharged 40.5% in this age group. A part of this age shift into older groupings may be due to the length of time out of service, since 41.2% of the patients, as shown in Table 10, were out of the service a year or more before they sought treatment. It is interesting to observe that the largest percentage for psychoneurotic cases in the clinic is 33.5 for 25-29 age group while the largest percentage for the total clinic is 38.3 in the 20-24 age group. The table further indicates that the psychoneurotic is likely to come for treatment at a later age than those in *general* in other neuropsychiatric diagnostic categories.

Sex.—The ratio of 1 female to 9 or 10 males in the clinic is markedly out of proportion to the relatively smaller number of females in military service(1). Further, our data reveal that more than twice as many psychotic females as males came to the clinic for treatment.

Marital Status.—Table 2 shows a striking difference in the marital status of our psychoneurotic group and the army discharges for psychoneuroses. In our group 41.9% were married at the time they came to the clinic as compared with 31.2% of the comparable army group. Although the latter shows a slight tendency toward the broken home, our group shows a definite increase

of divorces and separations at the time of intake. Many of our cases come in with problems of marital discord as the precipitating cause for clinical services.

Education.—In Table 3, our cases definitely show a considerably higher educational level than do the army discharges for psychoneuroses. This might suggest drive or aspiration both in the educational field and in seeking therapy. If primarily those with greater educational achievement seek therapy, it might be desirable to develop a program to reach the others with the lower level of intelligence or educational achievement, unless it is found that these latter may more readily fall into their prior way of life, which alleviates or does not further complicate their neuropsychiatric disability.

TABLE 2

MARITAL STATUS COMPARED WITH ARMY NP DISCHARGES AND TOTAL ARMY POPULATION

	Clinic		Army(2)	
	Total	Psychoneuroses *	NP discharges	Total population
	Percent	Percent	Percent	Percent
Single	50.4	47.3	63.4	59.9
Married	38.9	41.9	31.2	38.0
Divorced	7.5	9.5	2.5	1.4
Separated	2.8	1.3	0.5	0.5
Widowed	0.4	0.0	2.4	0.2
	100.0	100.0	100.0	100.0

* Army only, excluding commissioned officers.

TABLE 3

EDUCATION COMPARED WITH ARMY NP DISCHARGES AND TOTAL ARMY POPULATION (FULL YEAR)

	Clinic		Army(2)	
	Total	Psychoneuroses *	NP discharges	Total population
	Percent	Percent	Percent	Percent
Elementary school only (grades 1-8)	10.2	11.8	43.4	30.9
High school	63.6	63.2	45.1	53.2
College (including postgraduate work of 1 year or more)	26.2	25.0	11.5	15.9
	100.0	100.0	100.0	100.0

* Army only, excluding commissioned officers.

Employment.—On the whole, our cases shown in Table 4 represent poorer employment adjustment before induction into service than army psychoneurotic discharges. At the time that our patients appeared at the clinic the incidence of employment was low even after taking into consideration the large number of students and the fact that man power demands at these times have been for the most part on an increase. This definitely indicates the importance, from an economic point of view, that maladjusted veterans should receive treatment as soon as possible. Many of our patients do either secure jobs or become students as they begin to taper off or terminate treatment.

Source of Employment.—As shown in Table 5, our patients appear to be a little less versatile in making contacts for employment than the army discharges for psychoneuroses. Fewer return to the old job and fewer got jobs on their own even after taking into consideration the larger percentage of students in our group. These facts may be due to the incapacitation of the emotional disturbance felt by the person himself and his inability to establish satisfactory personal relations.

Medical Discharge.—There is believed to be a trend among employers to place less

emphasis than formerly on the medical discharge for neuropsychiatric disability in employing veterans; yet 19.7% of our cases, as shown in Table 6, reported that the medical discharge prevented them from getting employment one or more times. In the further analysis of the data, it is suggested that there may be a more compelling factor than the medical discharge itself in certain cases as indicated by the drop to 13.8% for psychoneurotic cases and an increase to 50% in all other diagnostic categories. The severity of the disability and its effect upon the personality may be a greater determinant for some veterans. However, we feel that in many cases, the satisfaction and security of employment resulting from careful placement have an alleviating effect upon the emotional disturbance. The potentialities of each veteran should be matched with employment opportunities rather than placing emphasis on the medical discharge in referring and hiring.

Health.—Self-estimation of health prior

TABLE 4

COMPARISON OF PRE-INDUCTION EMPLOYMENT WITH PRESENT EMPLOYMENT FOR THE CLINIC AND FOR ARMY NP DISCHARGES (SECOND HALF)

Clinic	Employed	Unemployed	Students	Total
Total	Percent	Percent	Percent	Percent
Before induction	79.6	17.2	3.2	100.0
At present	33.4	41.3	25.3	100.0
Psychoneuroses *				
Before induction	85.9	12.6	1.5	100.0
At present	46.9	33.1	20.0	100.0
Army NP discharges (2)				
Before induction	93.7	3.8	2.5	100.0
At present	85.9	13.1	1.0	100.0

* Army only, with commissioned officers excluded.

TABLE 5

SOURCE OF HELP IN FINDING EMPLOYMENT (SECOND HALF)

	Clinic		Army (2)
Source of help	Total Percent	Psychoneuroses * Percent	NP discharges Percent
Returned to old job	14.2	23.0	33.0
Secured new job			
No help	13.9	14.6	41.6
USES	3.5	3.1	8.6
Veterans Administration	0.0	0.0	.6
Selective Service	0.0	0.0	.7
American Red Cross	0.0	0.0	.6
Friends or relatives	5.0	3.8	6.1
Others	3.0	3.8	1.8
Unemployed	36.5	30.1	7.0
(Students)	23.9	21.6	
	100.0	100.0	100.0

* Army only, excluding commissioned officers.

TABLE 6

THE RELATION OF MEDICAL DISCHARGE TO EMPLOYMENT JOB OPPORTUNITY (SECOND HALF)

	Psychoneuroses * Percent	Others Percent	Total Percent
Medical discharge reported to eliminate job opportunity	13.8	50.0	19.7

* Army only, excluding commissioned officers.

to service was considered good by 81.1% of the total cases and 78.1% of our army psychoneurotic group as compared with 48.4% of the army follow-up studies, as shown in Table 7. This is evidence for the great attribution of poor health to the service. Our statistics reflect the feelings of the patient before treatment. After they are in treatment for a short time, many are able to admit that their feelings of having poor health antedated service.

NP Contacts.—Of the clinic cases 9.3% reported receiving some amount of neuropsychiatric treatment prior to service. It is of interest to note that among these cases there was only one psychotic. The percentage is rather high and might raise the question of the desirability of screening at induction on the basis of this factor. Orientation to psychotherapy prior to service may make it easier for the patient to resume treatment at this time.

Migration.—The population shift to California is indicated by the facts that only 19.1% of the clinic cases were born in California and that 61.6% were inducted in California. A migratory tendency may be significant in some of these cases as a part of the neuropsychiatric pattern of maladjustment, as well as resulting from a general trend in shifting of population.

Grade.—In general, our clinic cases are likely to be of a higher military grade distribution than that of the Army and especially the army discharges for psychoneuroses. In our psychoneurotic group 21.3% are at the grade of private as compared with 70.2% of those in the follow-up group, leaving respectively 53.9% to 15.9% above the grades of private. In comparison, then, with the grades of the general psychoneurotic discharges there is a definite tendency of the higher grades to be more active in seeking clinical services. Among the commissioned officers the clinic statistics show 5.9% for the army and 1.0% for the navy.

Foreign Service.—Of the total clinic cases for the "second half," 67.6% had foreign service and 31.1% of cases with foreign service were in combat. This indicates a relatively high percent of NP disability for combatants when it is considered that there was more careful screening for combat personnel than for others.

Length of Service.—Table 9 for the first half shows that 70.0% of the clinic cases spent one or more years in the service with 25.6% serving from 2 to 3 years. We might consider the period of 3 to 9 months with 21.7% as being another critical period representing the threat of combat and danger. In a short war of one year approximately 70.0%

TABLE 7

SELF-ESTIMATION OF HEALTH PRIOR TO SERVICE COMPARED WITH THE ARMY NP DISCHARGES (SECOND HALF)

	Clinic		Army(2)
	Total	Psychoneuroses *	NP discharges
Estimation	Percent	Percent	Percent
Good	81.1	78.1	48.4
Fair	16.1	21.9	42.8
Poor	2.8	0.0	8.8
	100.0	100.0	100.0

* Army only, excluding commissioned officers.

TABLE 8

ARMY MILITARY GRADE COMPARED WITH THE ARMY NP DISCHARGES AND THE TOTAL ARMY POPULATION (FULL YEAR)

	Clinic		Army(2)	
	Total	Psychoneuroses *	NP discharges	Total population
Grade	Percent	Percent	Percent	Percent
Private (including Aviation Cadet)	34.1	21.3	70.2	40.2
Private, First Class	18.3	24.8	13.9	21.0
Corporal (including Technician, Fifth Class)	14.9	21.3	9.0	18.3
Sergeant (all grades)	26.8	32.6	6.9	20.5
Commissioned Officers	5.9	...	...	...
	100.0	100.0	100.0	100.0

* Army only, excluding commissioned officers.

of our cases would make a passing adjustment to military life.

Time Out of Service.—Although the clinic had been in operation 6 months before these statistics were taken, and as is seen from the varied initial sources of referrals that the clinic is well known, only 12.2% sought some kind of help leading to the clinic within the first 90 days out of service. This suggests an attempt on the part of the patient to regain equilibrium and a solution on his own before seeking treatment.

TABLE 9

LENGTH OF SERVICE (FIRST HALF)

Time	Percent
Less than three months	3.3
Three to six months	10.0
Six to nine months	11.7
Nine months to one year	5.0
One to two years	19.5
Two to three years	25.6
Three to four years	15.5
Four years and over	9.4
	100.0

TABLE 10

TIME OUT OF SERVICE (SECOND HALF)

Time	Percent
One month or less	1.3
One to two months	4.4
Two to three months	6.5
Three to six months	17.7
Six to twelve months	28.9
One to two years	23.2
Two years and over	18.0
	100.0

Diagnostic Distribution.—Table 11 shows that about 9.0% of these cases are psychotic and therefore are potential hospital cases; but the fact that they can be carried by an outpatient clinic reduces proportionately the need for hospitalization among the discharged neuropsychiatric cases. Over half of this group were discharged from military service with a diagnosis of psychoneurosis, but our further study indicated evidence of psychosis. There is a large percentage of our cases in which anxiety symptoms predominate and are the motivating factors in seeking psychotherapy (*note:* 131 anxiety states—56 anxiety hysteria).

Closures.—Table 12 shows the type of closure of 64.9% of the treatment cases. As "recovered" connotes a character reformation and requires long term therapy, which is not considered the function of the clinic, this category is most likely to be small. The 2.3% of recovered cases would include manic-depressive, depressive phase, cases. The 34.8% "improved" cases indicates recoverability to the extent of a satisfactory social and economic adjustment. It is felt that the patient is as good as, or better than, when he entered military service. His conflicts are resolved to a large extent. The 22.7% cases receiving "maximum benefit" were those showing some forward movement during treatment, but because of well channeled defenses, could only go as far as their ego potentiality. This includes psychotics, psychopathic personalities and deep seated character neuroses. In the 9.1% "unimproved" cases, therapy was ineffective. The 31.1% cases that "failed to return" registered a desire for treatment and were placed in treatment status but failed to appear for psychotherapy at all or discontinued after treatment began. Although this group appears to be large, we have no figures for civilian mental hygiene clinics to compare it with, but it is our impression that they will be equally high.

TABLE 12

CLOSURES (SECOND HALF)

	Percent
Recovered	2.3
Improved	34.8
Maximal benefit	22.7
Unimproved	9.1
Failed to return	31.1
	100.0

Status of Cases.—Of the cases coming to the clinic 21.6% were placed in their diagnostic categories but did not receive treatment, for the following reasons: (a) ineligible for treatment, (b) not presently accepting treatment, (c) seeking other than clinical services, (d) recommended for hospitalization, (e) consultations rendered to other sections of the Veterans Administration, *e. g.,* vocational rehabilitation, (f) referrals from us to either community or other Veterans Administration resources. Of the

TABLE 11

DIAGNOSTIC DISTRIBUTION

	First half	Second half	Total
Psychoneuroses			
Hysteria	1	1	2
Anxiety hysteria	33	23	56
Neurasthenia	7	7	14
Anxiety state	35	96	131
Hypochondriasis	8	9	17
Reactive depression	2	7	9
Mixed psychoneurosis	2	23	25
Conversion hysteria, anesthetic type	1	1	2
Conversion hysteria, paralytic type	1	2	3
Conversion hysteria, hyperkinetic type	5	11	16
Conversion hysteria, paresthetic type	2	0	2
Conversion hysteria, autonomic type	0	7	7
Conversion hysteria, amnesic type	3	0	3
Conversion hysteria, mixed hysterical psychoneurosis	2	16	18
Psychasthenia, obsession	3	5	8
Psychasthenia, compulsive tics and spasms	3	7	10
Psychasthenia, phobia	1	2	3
Psychasthenia, mixed compulsive states	3	5	8
	112	222	334
Psychopathic Personality			
With pathological sexuality	4	8	12
With pathological emotionality	22	25	47
With asocial or amoral trends	5	0	5
Mixed type	0	1	1
	31	34	65
Primary Behavior Disorders			
Simple adult maladjustment	4	13	17
Diagnosis Undetermined	8	9	17
Psychoses			
Manic-depressive, manic type	1	2	3
Manic-depressive, depressive type	0	1	1
Manic-depressive, mixed type	2	0	2
Dementia præcox, simple type	4	11	15
Dementia præcox, hebephrenic type	1	2	3
Dementia præcox, catatonic type	0	2	2
Dementia præcox, mixed type	6	6	12
Involutional psychosis, paranoid type	1	0	1
Involutional psychosis, melancholia	0	1	1
Involutional psychosis, unspecified	0	1	1
Paranoid conditions	0	1	1
Post-traumatic cerebral syndrome	0	2	2
	15	29	44
Without Psychoses			
Epilepsy	3	5	8
Alcoholism	4	3	7
Drug addiction	1	0	1
	8	8	16
Final totals	178	315	493

78.4% treatment cases, 64.9% have been treated and closed and 35.1% are still in treatment status.

Summary of Data

Data were accumulated for a sampling of 493 cases in the Los Angeles Mental Hygiene Clinic from June 26, 1945, through June 30, 1946. There were 178 cases from the period of June 26, 1945, through December 31, 1945 and 315 cases from January 1, 1946, through June 30, 1946. The data were tabulated and converted into percentages. Certain items were compared with the army population findings on the follow-up study of discharges for psychoneurosis. According to the time intervals during which the data were accumulated the treatment of our statistical data led to the following generalizations:

1. Our case load has increased steadily since the inception of the clinic and the intake has shown marked augmentation as we have had personnel and adequate facilities to handle the load.

2. The clinic serves veterans with neuropsychiatric disabilities who have served in the Army, Navy, Marine Corps, and Coast Guard.

3. Those veterans seeking therapy for neuropsychiatric disabilities are likely to fall in an older age grouping than those among the army psychoneurotic discharges in the general population.

4. The percentage of female cases is greater than the proportion of females to males in the armed services.

5. There are more married veterans and a greater number of divorces and separations among those seeking clinical help than among the army psychoneurotic discharges in the general population.

6. The educational level of our case is considerably higher than a representative sampling of the army psychoneurotic discharges in the general population and total normal army population.

7. The neuropsychiatric cases appearing for treatment show a poorer employment adjustment both prior to service and after discharge than the army psychoneurotic discharges in the general population.

8. Veterans who appear for psychotherapy are less likely to return to their old job, less likely to find employment on their own and more likely to be unemployed than army psychoneurotic discharges among the general population.

9. The medical discharge for a neuropsychiatric disability is still an obstacle for this group of veterans in securing employment.

10. The clinical cases reported that their health was better prior to service than veterans of the general psychoneurotic discharge population of the Army.

11. About 10% of the clinical cases received some kind of neuropsychiatric treatment service prior to entering the military forces.

12. There is a marked shift of population to Los Angeles and vicinity among veterans with neuropsychiatric disabilities both prior to service and after discharge.

13. The military grade of those seeking neuropsychiatric treatment is likely to be much higher than the general population of the army neuropsychiatric discharges and total population of the Army.

14. Approximately two-thirds of the veterans seeking neuropsychiatric facilities have had foreign service and nearly half of those who have had foreign service have been in combat.

15. Over two-thirds of the clinical cases have served in the armed forces one year or more.

16. Better than three-fourths of our clinical cases did not seek neuropsychiatric treatment until after they had been out of service for 3 months or more.

17. Treatment of neuropsychiatric disabled veterans on an outpatient basis reduces the number of hospitalizations and social and economic incapacities accompanying such disabilities.

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PSYCHOSES ASSOCIATED WITH THE ADMINISTRATION OF ATABRINE

MARVIN F. GREIBER, M.D.[1]

Introduction

The administration of atabrine to our troops serving in endemic malarial areas was carried out on a large scale during the recent war. This drug was administered in therapeutic dosages for the treatment of malaria and in suppressive dosages to prevent the occurrence of clinical malaria.

Gaskill and Fitzhugh[2] in 1945 reported 35 cases of toxic psychoses following the administration of atabrine in the treatment of malaria.

The author, during the period from June, 1944, to November, 1945, while serving in the India Burma Theatre, observed 43 cases of psychoses in which atabrine was felt to be of etiological importance.

Method of Study

The evaluation of a psychosis can only be accurately made after a thorough study of the individual. The study and observations made during the psychosis, the physical findings and laboratory data should be supplemented by data which will give further clues to the individual's basic personality and his adjustment to environment, both civilian and military.

In order to study thoroughly the reactions encountered, the cases were investigated in the following manner:

1. Complete neuropsychiatric history of the patient.

2. Detailed history from the unit referable to adjustment in the unit; ability to get along with other men; date atabrine suppressive therapy was started; onset of the psychosis—acute or gradual; conflicts, if any, just prior to onset of psychosis; the picture the patient showed prior to entrance to the hospital; and all information referable to the patient as recorded in his service record and files.

3. Complete social history from the Zone of the Interior.

4. Detailed observations of the clinical course.

5. Blood atabrine studies.

6. Retesting in a number of cases.

7. Patch testing for possible sensitivity to atabrine.

8. Review of cases seen plus the acquiring of data not previously obtained in cases seen prior to the inauguration of the detailed study.

9. The division of cases into two groups; those who developed psychoses after the administration of massive atabrine therapy for malaria (2.8 grams of atabrine in 7 days) and those who developed reactions during the course of suppressive therapy (.1 gram daily).

Incidence of Psychoses and Psychoneuroses

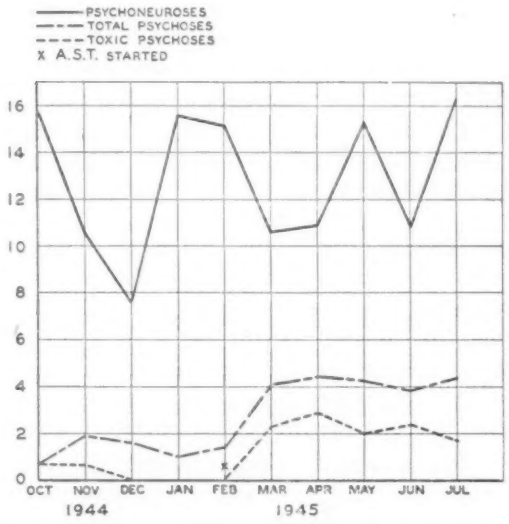
The incidence of psychotic and psychoneurotic reactions will, of course, vary, dependent upon the stress and strain to which a given number of troops are subjected in an overseas assignment. From October, 1944, to the conclusion of the present study on the atabrine psychoses, the 234th General Hospital serviced a definite geographic area. As this hospital was the only one which had facilities for the treatment of psychotic patients, all psychotics were immediately evacuated to the hospital either by ambulance or plane. In addition, all psychoneuroses needing definite therapy were sent there for treatment. As a result it was possible to study all psychoses that occurred in the area over this ten months' period.

The author had been in the geographical area with the troops being studied for a period of 24 months, and therefore was qualified to evaluate factors which might cause a rise in the incidence of psychiatric

[1] Assistant Professor of Neuropsychiatry, Department of Student Health, University of Wisconsin, Madison, Wisconsin.

[2] Gaskill, H. S., and Fitzhugh, T., Jr.; Toxic Psychoses Following Atabrine, Bull. of U. S. Army Medical Dept. No. 86, 63, 1945.

casualties. It may be stated that conditions that might have contributed to psychiatric breakdowns had improved rather than the contrary during this period. Living conditions, recreational facilities, post exchange supplies, better food and measures to counteract monotony and discontent had been instituted and had become increasingly better as time passed, and therefore should logically have helped the soldier to adjust more satisfactorily. In addition, the greatest percentage of troops had been in the area



GRAPH I.—Psychoneuroses and psychoses. Rate per 1000 per year.

12 to 14 months, during which time it could be expected that the seriously maladjusted and the psychotics would have been weeded out.

On February 15, 1945, a new factor was introduced, namely, atabrine suppressive therapy, and 37,589 troops who had never previously taken the drug (except those treated for malaria) were placed on this suppressive schedule. From October 1, 1944, to March 1, 1945, the diagnosis of a psychosis was made in 21 patients, a monthly average of 4.2 patients per month. In March, 1945, 15 psychotics were admitted to the hospital, the increase in the admission rate being well stabilized through July, 1945, as is illustrated in Graph I. This rise, in view of improvement in the environment, was felt to be due to one factor—the institution of suppressive atabrine therapy.

During the period of this study the psychoneurotic admission rate failed to show significant change.

THE ATABRINE FACTOR

In the study of the early cases it was discovered that the greatest percentage of cases occurred in individuals who definitely gave histories which would predispose them to mental disease, either in the psychoneurotic or the psychotic group.

Because of this factor we postulated the "atabrine factor," dividing cases into two categories: (1) Primary group—those individuals who from all data obtained proved to be well balanced and who would fall in the normal group from a psychiatric standpoint. (2) Trigger group—those individuals, who from their histories might fall prey to mental disease if the proper "trigger" mechanism were introduced, the atabrine being not the primary factor but merely the trigger mechanism for the production of a psychotic reaction.

Massive group		Suppressive group	
Primary *3*	Trigger *6*	Primary *6*	Trigger *28*

When the basic personalities of the individuals in the trigger group were analyzed, they fell into the following categories:

	Massive group	Suppressive group
Cyclothymic	4	7
Schizoid	2	5
Emotionally unstable	0	12
Psychopathic	0	3

As the greatest percentage of the psychoses fell into the suppressive group it was decided to evaluate the reactions to determine if the time of occurrence of the psychosis differed in the primary and trigger groups. It was discovered that all the primary reactions in the suppressive group occurred after the individual had taken from 4.4 grams to 8.4 grams of atabrine, all reactions in this group occurring from the 44th to 84th day of administration of the drug, the average atabrine taken being 6.2 grams. This varied widely from the "trigger" reaction types, who became psychotic as early as the 17th day of suppressive therapy (1.7

grams of atabrine), and who also became psychotic as long as 5½ months after suppressive therapy had been started.

Psychoses Following Massive Atabrine Therapy

During the period from June, 1944, to November, 1944, 9 cases of toxic psychoses were encountered. These patients had all received the massive treatment for malaria, 2.8 grams of atabrine, with the exception of 1 case in which the psychosis developed on the 6th day of treatment (this patient received 2.5 grams of atabrine). In this group 6 of the reactions were manic in type, while 3 were schizophrenic-like reactions. In 5 of the cases the malarial infection was of the benign tertian type, while in 4 the infection was of the malignant tertian or estivo-autumnal type. In all cases studied the reaction was acute in onset and characterized by sudden, explosive bizarre behavior, which required either immediate evacuation to the hospital or transfer to the neuropsychiatric service. The psychotic reactions occurred from the 6th to the 13th day of treatment, 7 of the 9 cases becoming psychotic 7 to 10 days after treatment had been started. The duration of the psychotic response varied from 12 to 30 days, the average duration being 21 days.

Of the 9 cases studied, 8 were returned to full duty, while 1, who had recurrent bouts of benign tertian malaria and who had given a history of a psychosis with a lobar pneumonia 10 years previously, was sent to the Zone of the Interior. One of the cases was returned to duty in another area and was placed on suppressive atabrine therapy. He was readmitted to another general hospital 6 weeks later, where the diagnosis of a toxic psychosis was also made, and he was returned to the Zone of the Interior.

Psychoses Encountered During Atabrine Suppressive Therapy

The largest number of cases studied were those encountered in the course of atabrine suppressive therapy. These cases were seen from the period of March, 1945, through July, 1945, suppressive atabrine therapy, .1 gram daily, having been started on February 15, 1945.

Thirty-four cases were encountered in this group. In the series as a whole the number of grams of drug taken did not play a significant rôle except in the group which was considered to be the "primary" group.

Twenty-one manic-like reactions occurred in this group, as did one depressed reaction. Eleven schizophrenic-like reactions occurred; 4 of these showed predominantly paranoid features, 4 presented depressed catatonic features with catatonic excitement and pseudocatatonia, while the remaining 3 presented a confused hebephrenic picture with silly, bizarre behavior and vivid hallucinations, mostly in the auditory sphere.

Of the 34 cases studied, 30 returned to full duty, and 4 were returned to the Zone of the Interior.

Clinical Pattern

When a study of the toxic psychoses is undertaken it is of importance to determine if possible a clinical pattern and course which will aid in differentiation from the constitutional psychoses.

The reactions in our cases fell into two general categories; a manic-like and a schizophrenic-like reaction. Twenty-seven of the cases demonstrated manic reactions. In all these cases the onset was sudden, acute and explosive, the patients being admitted either by litter under the influence of heavy sedation, or brought in by five or six fellow soldiers trying their utmost to control the patient. These individuals displayed marked hyperactivity, were constantly euphoric, were very fearful, were often combative and destructive, and displayed a marked flight of ideas. Delusions were common and hallucinations in both the visual and auditory spheres were present. Their hospital course was characterized by periods of the above mentioned behavior interspersed with periods of apparent lucidity during which the patients were pleasant, cooperative and seemingly normal. The maintenance of physical nutrition was not a problem in this group, as these individuals took huge quantities of nourishment at all times. During the periods of agitation this group was exceedingly de-

structive, tearing up pajamas, mattresses and even beds as they released their excess energies. In the suppressive group the reactions lasted from 25 to 30 days, the return to normal occurring in a period of 24 to 48 hours. In the group encountered with massive atabrine therapy the duration of the psychoses was shorter, "clearing" occurring in 14 to 21 days.

Fifteen cases demonstrated schizophrenic-like reactions that were classified in 3 large groups, the catatonic, paranoid and hebephrenic.

The catatonic group was made up of 6 cases. The onset in 2 of these was acute and explosive, with catatonic excitement present on admission to the hospital. This stage was characterized by stereotyped movements such as clapping the hands and saluting repeatedly, echolalia, repetition of Indian phrases with exclusion of the English language, delusions, auditory hallucinations, and extreme combativeness and destructiveness. The excitement lasted for 10 to 14 days, after which the individual became pseudocatatonic. In this period the patient often assumed catatonic postures, but in general was dull and listless, with a paucity and deliberateness of motor activities being a predominant part of the picture. One of the patients in this group was admitted in a catatonic stupor which persisted for 4 days, after which he became pseudocatatonic and then returned to normal. The remaining 2 patients in this group were admitted in a pseudocatatonic state, this state having gradually developed over a period of 48 hours. In these cases the return to normal was gradual and occurred in a period of 25 to 35 days.

In the paranoid group 5 cases were seen. In all of the cases the onset was acute and explosive, 3 being admitted in an acute combative state from their units. Two other cases had suddenly, on the morning of admission, developed delusions of persecution directed towards other members of the unit, while one was admitted with grandiose delusions as to wealth with a basic paranoid trend directed toward other members of the unit. Four of these patients, although markedly paranoid, were extremely euphoric at all times and were not problems in the ward. In these cases the paranoid trend gradually receded in 3 to 4 weeks, and then suddenly disappeared. The fifth case in this series was extremely paranoid for 3 weeks; he was combative and fearful, neglected all personal hygiene, ate insects, attempted to eat feces, refused all nourishment both liquid and solid, and became suicidal, attempting to gouge out his eyes and kill himself by butting his head against the wall. This patient remained in this state for 3 weeks and then cleared spontaneously over night. When seen on the following morning he was oriented, cooperative and pleasant, Close questioning failed to reveal any paranoid trends. From this period, until discharge from the hospital one month later, this patient remained normal in every respect.

Four cases were seen in the hebephrenic-like group. The onset in these cases was also sudden, the patients usually being admitted because of bizarre behavior which had occurred prior to hospitalization. One of these individuals, a photographer in the Signal Corps attached to an Air Corps Base, on the morning of admission, stole a pilot's flying equipment, managed to get into a plane at his base and almost succeeded in an attempt to take off before he was forcibly removed from the plane. Another patient, a pilot in combat cargo, was found in the office of his commanding officer in a disheveled condition, minus his shirt, sitting in the chair of the commanding officer with his feet perched on the desk. When reprimanded by his commanding officer, the pilot with a foolish grin commented, "Oh, Major, don't get your bowels in an uproar." The behavior of these patients in the hospital was characterized by a total neglect of personal appearance, vivid hallucinations in the auditory and visual spheres, and silly, superficial behavior. As a group they gradually improved after 2 or 3 weeks and returned to normal at the end of this period.

After a number of cases had been observed it was decided to set a definite time limit as to the duration of the psychosis to serve as a guide in the differentiation from a constitutional psychosis. If the psychosis did not clear after a maximum period of 35 days it was classed as constitutional. Observations in future cases tended to substantiate this criterion for it was found that cases

eliminated by this method continued to remain psychotic for as long as 60 to 90 days, at which time they were evacuated to the Zone of the Interior.

In conclusion, the clinical picture was characterized by an acute, explosive onset in all cases except the pseudocatatonic group where psychoses developed gradually over a period of 1 to 2 days. The reactions as a whole were characterized by a stormy course which cleared suddenly in a period of 30 to 35 days.

Physical Findings and Laboratory Data

Physical examination on admission was negative in all cases. Three cases, all in the catatonic excitement group, developed high fever, rapid pulse and high blood pressure without pertinent physical findings about a week after hospitalization. All studies to determine etiology of the fever, including blood studies with repeated malaria smears, urine studies, agglutinations, stool cultures and spinal fluid studies, showed normal findings. These cases were given supportive treatment and heavy sedation, and made an uneventful recovery in a week to ten days.

Routine laboratory studies were performed in all cases and were universally negative except in one case who developed a hypochromic anemia. Blood Kahns were positive in two cases but spinal fluid findings were normal.

Retesting

Retesting with atabrine was performed in 20 cases, 2 being retested while on duty under the supervision of their medical officers. Three of the cases in the massive group were in reality tested as well, for on follow-up it was discovered that 2 of these individuals had been on atabrine suppressive therapy for 5 months without any adverse effects. These 2 cases were in the *trigger* reaction group, The third case in the massive group, also retested by the advent of suppressive therapy, became psychotic after the administration of 4.2 grams of atabrine and was readmitted to the hospital for treatment. This individual fell into the *trigger* group as well.

Retesting in the hospital was done in the following manner. When, in our opinion, the psychosis had subsided, the patient was moved to an open ward, where he became one of the group and partook in all activities, *i. e.*, group therapy, occupational therapy, ward duties, etc. At the end of 2 weeks he was given massive atabrine therapy in a disguised form. The patient was told that he was to receive capsules to help build up his strength. He was not restricted in his activities or given unusual care by the ward personnel. In several cases identical capsules containing sugar were given, after which the atabrine capsules were given. Needless to say, the sugar capsules did not reproduce a psychotic reaction.

On retesting in the hospital, all individuals being retested became psychotic with the exception of 2 who fell into the "trigger" group. The psychotic reactions produced were similar to the initial reactions in all cases, but the duration of the psychosis was, as a rule, shorter except in 2 cases. The 2 individuals retested on duty were retested by different methods. One patient who did not become psychotic when retested with massive therapy (2.8 grams of atabrine) was continued on suppressive therapy for 2 weeks. After this period he was sent to duty on suppressive therapy. At the end of one week he was readmitted in a psychotic state, after having taken a total of 4.9 grams of atabrine. This patient fell into the primary group, his initial psychosis occurring after the ingestion of 3.8 grams of the drug. The second case, also one of the primary group, was not placed on the massive régime, but took atabrine suppressive therapy for 18 days in the hospital. Suppressive therapy was continued while on duty, and he again returned psychotic 10 days later after having taken 2.8 grams of the drug.

Of the 20 cases retested, 15 were in the trigger group, while 5 were in the primary group. All cases in the primary group became psychotic on retesting, while 4 failures occurred in the trigger group. The results

of retesting can best be shown in the following table:

RESULTS OF RETESTING OF NINETEEN CASES OF ATABRINE PSYCHOSES

Reaction	Atabrine factor	Type of test	Where done	Result
Manic	Trigger	Suppressive	Duty	Negative
Pseudocatatonic	Trigger	Suppressive	Duty	Negative
Manic	Primary	Suppressive	Duty	Positive
Manic	Primary	Massive and suppressive	Duty	Positive
Manic	Primary	Massive	Hospital	Positive
Catatonic	Primary	Massive	Hospital	Positive
Manic	Primary	Massive	Hospital	Positive
Manic	Trigger	Massive	Hospital	Positive
Hebephrenic	Trigger	Massive	Hospital	Positive
Depressed	Trigger	Massive	Hospital	Positive
Hebephrenic	Trigger	Massive	Hospital	Positive
Manic	Trigger	Massive	Hospital	Positive
Manic	Trigger	Massive and suppressive	Hospital	Negative
Paranoid	Trigger	Suppressive	Duty	Positive
Depressed pseudocatatonic	Trigger	Massive	Hospital	Positive
Manic	Trigger	Massive and suppressive	Hospital	Negative
Manic	Trigger	Massive	Hospital	Positive
Manic	Trigger	Massive	Hospital	Positive
Paranoid	Trigger	Massive	Hospital	Positive
Manic	Trigger	Massive	Hospital	Positive

Presence or Absence of Other Toxic Symptoms

Gastrointestinal symptoms and skin lesions, often considered toxic manifestations secondary to the administration of atabrine, were not seen in our series prior to the onset of the psychoses. One case, however, had experienced mild anxiety, belligerence and arrogance for two months prior to the onset of his psychosis.

Reversibility of the Psychoses

Although a series of only 43 cases has been studied it is the opinion of the author that the reaction is not a permanent one, and that the individual suffering from an "atabrine psychosis" does not suffer permanent damage, either functionally or organically, because of the psychosis. This observation has been well substantiated in the high percentage of patients returned to duty, especially in the group that was retested; for of 16 patients retested, who again became psychotic, only one was evacuated to the Zone of the Interior for further observation.

Five cases were evacuated to the Zone of the Interior as toxic psychoses, and a sixth case, who had recovered from his psychosis, was later evacuated from another general hospital after he had developed a second psychotic reaction when placed on atabrine suppressive therapy.

Five cases were evacuated from our hospital; one individual had recurrent bouts of malaria with a previous history of a toxic psychosis; one, on retesting, developed a severe manic reaction; one, a pilot, was evacuated as his psychosis disqualified him from flying, and two others were evacuated because of the severity of their reactions.

Skin Testing

Patch tests to determine epidermal sensitivity to the drug were done in 15 cases with 15 controls obtained from the psychoneurotic group. Skin sensitivity was present in only one case, a control case. In view of the negative results obtained in this series, this test was discontinued.

Blood Atabrine Studies

Blood atabrine studies, which were not available during the study of the psychoses

following massive atabrine therapy, were performed in 25 cases of the suppressive group. These studies were carried out through the courtesy of the Malaria Commission at the 20th General Hospital.

Levels were taken on admission to the hospital and when the patient recovered from his psychosis. Levels over 50 gammas per liter were found in a number of the cases with several going as high as 80 to 100 gammas per liter. However, others were found to be in the 30 to 40 gamma range which was considered as slightly above normal for the area.

An effort to correlate these levels with the psychosis was impossible as many individuals, non-psychotic, in a control group from the surgical wards of the hospital had equally as high a level as the psychotic group. The author also had the privilege of reviewing the reports of blood atabrine levels at the laboratory of the Malaria Commission where identical data were found.

The impossibility of using blood atabrine levels was further substantiated in one case that was retested. This soldier on retesting did not become psychotic after massive atabrine therapy and two weeks of suppressive treatment. He was returned to duty and prior to discharge a level was taken which proved to be 65 gammas per liter. Two weeks later he returned psychotic, at which time his atabrine level was only 50 gammas per liter.

Etiologic Considerations

In the series of 43 cases the reactions have been classified either as primary or trigger reactions. As 34 fell into the trigger group and only 9 fell into the primary group, it must be assumed that the etiological significance of atabrine varied in the two groups. As previously stated, all individuals in the primary group became psychotic between the 44th and 68th days of atabrine suppressive therapy, the average amount of atabrine taken being 6.2 grams of the drug. The 3 cases of primary reactions encountered in the massive atabrine group became psychotic after 2.8 grams of atabrine had been taken. However, in this group an infectious disease with high fever and systemic symptoms was a definite factor which could lower the individual tolerance to the drug; this factor being absent in the suppressive group.

It is the opinion of the author that the individuals in the primary group were definitely sensitive to the drug, a fact which was further substantiated when retesting was done. Of the 5 primary cases retested, all became psychotic on retesting, while in the trigger group, in which 15 were retested, 4 failures resulted. What the nature of the sensitivity to the drug was, is impossible to determine. It must be assumed that the sensitivity in these individuals was of an "allergic" nature and that organic pathology does not result from the administration of the drug.

Information from units also helped in the determination of possible etiological relationship in the trigger group as many histories from the unit contained reports of emotional conflicts which had occurred prior to the individual's hospitalization. In order to evaluate this the unit's information was reviewed in the suppressive cases. In the primary cases, emotional conflict prior to hospitalization could not be ascertained. However, in the trigger group 24 of the 28 cases studied had a history of definite conflicts prior to hospitalization, while 2 cases had their onset during the course of an acute illness as stated below.

Conflict in unit	9
Familial difficulties (death and sickness in family, etc.)	4
Unfaithfulness of wife	2
Excessive drinking while on leave (admitted from rest camp)	2
Fear of flying new route in new type of plane	2
Conflict with tent mates over religion	1
Assuming added responsibility in unit	1
Sudden discontinuance of romance (by letter)	2
Unsuccessful romance with Red Cross worker	1
Onset during course of amœbic dysentery	1
Onset three days after recovering from acute illness	1

It is interesting to note that 2 cases of the trigger group who became psychotic after massive atabrine therapy have been on suppressive therapy for 5 months without the appearance of mental abnormalities.

When one has seen psychiatric casualties over a period of 22 months in a particular area where psychoses had been relatively

uncommon the following formula might be postulated:

(Predisposed personality)
+(emotional conflict)=(psychoneurosis).

However, when the atabrine factor is added the following formulæ can be postulated both in the primary and the trigger group:

Primary

(Stable personality)+(atabrine)+(individual sensitive to atabrine)=(psychosis).

Trigger

$$\text{(Predisposed personality)} + \left\{ \begin{array}{c} \text{emotional conflict} \\ \text{or} \\ \text{acute illness} \end{array} \right\} + \text{(atabrine)} = \text{(psychosis)}.$$

Treatment

Treatment in the toxic psychoses falls into 3 broad categories: (a) maintenance of body nutrition, (b) adequate sedation, and (c) withdrawal of the toxic agent.

Nutrition was not a problem in the majority of the patients. However, in the paranoid and catatonic group many of the patients refused nourishment. In these patients both tube feedings and small doses of insulin to stimulate the appetite were necessary. The periods of excitement were treated by the frequent use of cold packs, showers, and the administration of sedatives, sodium amytal and paraldehyde being the drugs of choice. In some of the cases insulin was used as well.

Results

Forty-three cases of toxic psychoses associated with the administration of atabrine were studied over a period of 14 months. Of this group 37 (86 percent) were returned to full duty.

Individuals returned to duty were either placed on quinine suppressive therapy or transferred to an area where suppressive therapy was unnecessary. In addition, each individual was given a certificate which stated that he was sensitive to atabrine and was not to take the drug in the future.

It was possible to follow 30 of these individuals either as out-patients or by questionnaire for a period varying from 2 to 8 months. At the end of this period there had not been a single readmission to a hospital for psychiatric treatment. However, 3 individuals complained of chronic headache and irritability, these symptoms not being incapacitating.

Summary and Conclusions

1. Forty-three cases of psychosis associated with the administration of atabrine, 9 of them secondary to the massive treatment for malaria, and 34 following atabrine suppressive therapy, have been studied.

2. The reactions most frequently encountered were manic-like reactions, seen in 27 cases, while 15 schizophrenic-like reactions were seen. One depressive reaction was seen.

3. The reactions were characterized by an acute sudden explosive onset, a stormy course and a return to normal in a period of 30 to 35 days.

4. In an effort to determine the etiological relationship of atabrine in the study of the psychoses an atabrine factor was postulated, dividing the reactions into a primary and a trigger group. Thirty-four reactions occurred in the trigger group, whereas only 9 reactions occurred in the primary group.

5. It was found that the primary group displayed a true sensitivity to the drug, whereas in the trigger group a predisposed personality as well as emotional conflicts or acute illnesses were as great a factor as the atabrine itself.

6. Retesting with atabrine was performed in 20 cases; 13 being retested with the massive schedule, 4 being retested on the suppressive schedule, and 3 being retested by the massive schedule followed by suppressive schedule. Of the 5 cases in the primary group, which were retested, all became psychotic; 3 being retested by massive therapy, 1 by massive and suppressive, and 1 by suppressive therapy. Of the 14 cases in the trigger group there were 4 failures; 2 of

these received the suppressive régime while 2 received the massive plus the suppressive régime, the rest receiving the massive régime.

7. Blood atabrine studies were not found to be a reliable aid in the diagnosis of a toxic psychosis due to atabrine.

8. Treatment in the toxic psychoses consists of withdrawal of the toxic agent, the maintenance of body nutrition and adequate sedation.

9. Of the 43 cases studied, 37 individuals (86 percent) were returned to duty,

10. Thirty of the 37 individuals returned to duty were given follow-up study for a period varying from 2 to 8 months. In this group there was not recurrence of the psychosis.

LABORATORY FINDINGS IN AFFECTIVE AND SCHIZOPHRENIC PSYCHOSES

MERRILL THOMAS EATON, JR., M.D.,[1] AND HASCALL H. MUNTZ, M.D.[2]

INTRODUCTION

Laboratory tests as aids in the diagnosis and prognosis of disease fall into two groups: those of a specific character relating to the presence of the etiological agent or to the failure of a certain organ; and those tests of a non-specific character which merely show the nature and extent of the disorder of bodily processes concomitant to disease.

Tests of the first type have their place well established in psychiatry in the diagnosis, for example, of paresis or bromide intoxication. However, little use is made of the other type test. Variations from normal in the results of common laboratory procedures done on patients with affective and schizophrenic psychoses must be expected for several reasons, among them the effect of emotion and mood upon the gastro-intestinal, circulatory and endocrine systems; changes in dietary habits; and changes in activity.

Since such variations are present they may be of some value. It is the purpose of this survey to review the variations in laboratory findings which might be useful in the following ways:

1. To follow the course of patients with these conditions who are under treatment and aid the therapist in observing the degree of return toward the normal state.

2. To aid the internist practicing in a mental hospital to sort out those findings occasioned by the psychoses studied from those of intercurrent disease.

3. To protect the patient with an early schizophrenic or affective psychosis who is taken to a general hospital or clinic from unnecessary diagnostic or therapeutic instrumentation, or delay in receiving psychiatric care, based on abnormal laboratory findings and misguided enthusiasm for finding "something organic" to account for the symptoms.

It is not meant to suggest the substitution of a laboratory diagnosis for careful examination of the patient, nor to imply that reasonable studies to exclude other diseases should not be undertaken, but only that in both the psychiatric and the general hospital from time to time knowledge of these matters might prove useful.

In reviewing the literature on the common laboratory tests as applied to patients with schizophrenic and affective psychoses those determinations belonging exclusively to the field of psychiatry and neurology such as the electroencephalogram and the galvanic skin reflex are excluded, and no attempt is made to survey the abundant literature in which attempts are made to prove a specific endocrine or bacterial etiology for these conditions, since all these subjects are well reviewed elsewhere. Also avoided are procedures of an unusual, technically difficult or complex nature impractical for the purpose listed. Even with these limitations there are nearly 700 papers dealing with experimental work on this subject since 1920.

Changes in blood chemistry in schizophrenic and manic-depressive psychoses reported prior to 1938-39 were well reviewed by McFarland and Goldstein (1,2), and information concerning a number of laboratory tests in these illnesses is to be found in the books of Katzenelbogen (3) and Hoskins (4); but for the most part studies on the subject have been aimed at other goals than those listed here. Many reports deal with attempts to discover or prove an etiology, or point the way to a new therapy, or to establish or subdivide clinical entities, and neglect other possible applications.

Some of the reports are conflicting. The conflicts are due to a variety of causes, among which are failure to use adequate series of cases to prevent chance distribu-

[1] Colorado State Hospital, Pueblo, Colorado.
[2] Department of Internal Medicine, Indiana University Medical Center, Indianapolis, Indiana.

tions, failure to apply statistical methods, failure to use identical techniques, and the use of an arbitrary normal value which fails to take into account differences in reagents, techniques, and the age and sex distribution of the patients. In some cases disagreement seems to be the result of the use of different diagnostic criteria in selecting the experimental group; and frequently the exact classification, symptomatology and stage of the disease are not specified. In a few instances conclusions stated by authors are not the only ones which may be drawn from their data.

Some of the material reviewed is based upon laboratory studies of consecutive admissions to mental hospitals with little regard to diagnosis; in other instances material relevant to the affective and schizophrenic psychoses is presented with inadequate attention to subclassifications. Few authors studied made reference to those cases manifesting both schizophrenic and affective elements or to cases intermediate between those conditions and mental health; and it is in those two types of cases where laboratory findings might have greatest diagnostic value as well as service for the purposes listed here.

In the use and definition of diagnostic terms that of the authors cited is used as far as possible, but with some changes for purposes of uniformity.

Despite conflicts in results, differences in terminology, and other sources of confusion mentioned abnormal laboratory findings in some of the conditions studied are clearly established. In other instances, such as those in which little work has been reported, and those in which reported work neglects subclassification, the known facts can do no more than point the way for future research.

It will be apparent that with nearly 700 references available it is impossible to list and discuss the merits of each, assign priority, and tabulate evidence for and against certain conclusions. Instead, a majority opinion and a rough estimate of the frequency of certain findings based on an average or trend of several reports are presented. Where agreement is almost unanimous the matter is stated as a fact; otherwise the statement is qualified appropriately.

In presenting the results of this survey an attempt is made to give considerable detail on the more common and simpler procedures which might be useful for the purposes outlined, and to give passing mention to other available tests. A sufficient number of references is listed on each subject to provide a starting point for one interested in further investigation.

Blood Sugar

The fasting blood sugar of patients with affective and schizophrenic psychoses is usually within normal limits; however, glucose tolerance tests frequently show abnormalities. Though there are a few dissenting opinions it seems probable that half or more of schizophrenics, melancholics and depressives have an atypical glucose tolerance curve(5, 6, 7, 8, 9, 10, 11). For the iconoclast who believes all such cases must have a latent or subclinical diabetes, or for the psychiatrist interested in the psychosomatic aspects of diabetes this fact is subject to varying interpretations; but for the purposes listed here it appears most valuable. The chief problem seems to be in deciding what modification of the test to use and how to describe the abnormal findings.

The usual technique of administering orally to the fasting patient 50 gms. of glucose(7), or a similar dose based on body weight(5), and recording the blood sugar at half hour intervals for a period of two hours, should in the normal subject result in a maximum blood sugar of 160 milligrams percent, or less, and a return to the fasting level by the end of the two hour period(6). In these conditions the maximum is likely to be higher or the return to normal delayed, or both.

In addition to study of the maximum level of the blood sugar and the duration of its elevation, other means of evaluating the results obtained have been used. The area of the curve(10) determined by the formula $A=(D\times M)/2$ where D is the duration of elevation in hours and M is the maximum rise above the fasting level in units of 100 milligrams percent, should give a value for A of 0.20 to 0.40 in healthy people. The frequently used hyperglycemic

index (H.I.), determined by the following formula:

$$\text{H.I.} = \frac{100\ (2\text{ hr. blood sugar level—fasting level})}{(\text{maximum level—fasting level})}$$

gives normal values of 0 to 10(7, 10).

These formulae, useful as they are for statistical comparison, fail to disclose all possible abnormalities of the tolerance curve. If the curve is to be evaluated by inspection, and the relatively narrow limits for normal mentioned be accepted; then care must be taken not to overestimate the importance of minimal variations, since these occur in some normal subjects. One must also differentiate between the curves found in these conditions and those in diabetes, Graves' disease, and liver dysfunction. Changes in sugar metabolism during menstruation may also be confusing.

Modifications of the glucose tolerance test including the Exton-Rose technique(4), and the intravenous method(12), are probably equally useful, though there is disagreement in regard to the intravenous test(4). Apparently the abnormal glucose tolerance curves in patients with affective and schizophrenic psychoses are not the result of the nutritional state or the transitory emotional changes evoked by the procedure.

For confirmation, in addition to the modifications of the glucose tolerance test mentioned, other closely related procedures such as the galactose and levulose tolerance tests may be used. The galactose tolerance test (13) is an easy one to perform since it involves only administration of varying doses of galactose and testing the urine for sugar (Benedict's test) to determine the smallest dose causing sugar to appear. Normal men should tolerate 30 grams, while women before puberty tolerate 20 grams and after puberty 40 grams. Decreased tolerance to galactose has been reported in about half of schizophrenics.

In a healthy individual the administration of 50 grams of levulose should not result in over 20 percent increase in blood sugar and a secondary hypoglycemia should occur 30 to 90 minutes thereafter. Levulose tolerance is reported decreased in schizophrenia and manic-depressive psychoses and three types of abnormal curves have been described(14).

Of possible additional value in cases where the normality or abnormality of sugar metabolism is in doubt are various tests of insulin tolerance(15), adrenalin tolerance (16, 17), and the reaction to ephedrine(18). Interesting, though impractical for the purposes outlined here, are animal experiments purporting to show an anti-insulin factor in the blood of schizophrenics(12), and a high insulin level in the blood of excited psychotics(19).

While investigation of sugar metabolism is being made caution must be observed that the patient does not receive barbiturates or other hypnotics(20).

Blood Lipoids

Variation in blood cholesterol in normal people is rather marked, a normal range being from 110 to 195 milligrams percent, with an average of about 150(21, 22). Because of the variability and range of lipoid values both in normal subjects and in these patients, tests based on them are less useful than those of glucose tolerance. It is generally agreed that cholesterol levels tend to be high and frequently are above normal limits in manic-depressives while values below normal limits are common in schizophrenics though hypercholesteremia is found in some cases (21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32).

Determinations of other lipoid constituents of the blood show abnormalities paralleling the cholesterol changes (22, 23, 28, 30, 32). The rise in cholesterol following a high fat meal is said to be greater in manic depressives than in normal people(33).

In addition to quantitative determinations of cholesterol and other lipoids the determination of iodine numbers has been suggested(31, 34), and the cholesterol-cholesterol ester and cholesterol-phospholipin ratios have been investigated(32).

Nitrogenous Constituents of the Blood

Abnormalities of nitrogenous constituents in the blood of patients with these conditions are not striking. A low fasting urea level has been reported in the melancholic group,

and glycine tolerance has been studied(35). In normal subjects the oral administration of 10 grams of glycine and comparison of fasting blood urea level with levels at five hourly intervals thereafter will show an increase of about 6.5 milligrams percent with return to fasting level by the end of the five hour period. An abnormal curve may consist of a more marked increase in blood urea (of about 14 milligrams percent), or a less marked elevation which continues throughout the five hour period. Such abnormalities are reported in melancholics and schizophrenics.

Other abnormalities reported include an increase in undetermined nitrogen(36) in depressives, melancholics and deteriorated schizophrenics; and an increase in creatine nitrogen(36) in simple and deteriorated schizophrenics and involutional melancholics.

A study of serum proteins(37) has shown the proportion of euglobulin to be low in schizophrenics.

Inorganic Constituents of the Blood

The normal serum calcium level is 9 to 11 milligrams percent. Though not all investigators agree it seems possible that an appreciable number of schizophrenics and manics have calcium levels above 11 milligrams percent and some have levels above 12 milligrams percent; there may be a tendency toward low levels in depressives (38, 39, 40, 41, 42, 43). A slight elevation of serum potassium may occasionally be found in schizophrenics(42); and an elevation of blood phosphorous may also be found(40).

Blood iodine is normally 1.5 to 4.0 gamma per cent; one investigator(44) reported over 36 percent of manics had blood iodine above 6.0 gamma percent, but 18 percent had less than 1.5; 36 percent of depressives were below 1.5.

Normal blood bromine is 0.8 to 1.0 milligrams percent; some investigators(45) have reported markedly reduced values in schizophrenics and manic-depressives.

Red cell chlorides have been reported to be high in schizophrenics(46).

The Formed Elements of the Blood

White blood counts over 10,000 may be found in about 25 to 50 percent of patients with these conditions, and in some instances counts over 15,000 will be found in the absence of demonstrable infection(47, 48). Normal transitory emotional changes and activity have some effect on the white count in controls, but such factors do not altogether account for the findings in these patients.

Reports of variations in erythrocyte sedimentation rate are conflicting(49, 50, 51), but it seems probable that there is a tendency toward increased sedimentation rate in catatonic and hebephrenic schizophrenia, but not in the other mental diseases studied here.

Care must be taken in evaluation of increased leukocyte count and sedimentation rate to exclude infection.

Changes in erythrocyte fragility have been reported(52) with slight or moderate deviation in both directions being encountered, but the over-all tendency is said to be toward increased fragility in schizophrenics and manic-depressives. Prolonged coagulation time has been reported(53).

Reference is not made to red blood count and hemoglobin level since so many variable factors play a part in their establishment. Statistical studies of the frequency of certain blood types are of no direct clinical interest.

The Circulatory System

Circulatory inadequacy in schizophrenia has been frequently hypothesized with comment being made upon the areas of cyanosis occasionally observed and the x-ray and autopsy findings of small hearts and diminished vascular bed in some patients; but for the purpose of this study tests of circulatory function offer little help.

The basal blood pressure in schizophrenia, systolic and diastolic, tends to be somewhat lower than in the general population. This is also true, but less markedly so, in the manic-depressive psychoses(54, 55). Since the average pressures in these conditions are only 5 to 15 millimeters of mercury below averages for normal groups, the extent of the normal range renders the blood pressure alone in a given case of little significance. One report states(56) that the ingestion of 200 grams of milk fails to alter the blood pressure in normal resting subjects but

causes it to be lowered in both manic-depressives and schizophrenics. It has also been reported(57) that adrenal cortical substance evokes a pressor response in a high percent of schizophrenics but in only a small percent of controls. The blood pressure changes evoked by different doses of adrenalin and ephedrine have been studied(58, 17, 59).

Findings concerned with circulation time (60, 61, 62), blood volume(63, 64, 65) and variations between oral and rectal temperatures(66, 67) are of doubtful value in the individual case due to marked overlapping of normal and abnormal ranges. However, the existence of essential oral hyperthermia (66) should be borne in mind.

Discussion of capillaroscopic research, measurements of the vascular bed of the retina, and other studies of the vascular tree are omitted as being beyond the scope of this survey.

Spinal Fluid Examination

Abnormalities of the protein or cellular content of the spinal fluid, though they are found in 3 to 5 percent of consecutive admissions to mental hospitals without other cause, are much more often associated with neurological disorders which may have mental symptoms and so require further investigation(69, 70, 71).

The permeability quotient, or blood-cerebrospinal fluid barrier, has received considerable investigation. Bromide penetration (39, 72, 73, 74, 75, 76, 77, 78) is determined by giving the subject, by mouth, 0.01 grams sodium bromide, t.i.d., for five days; on the sixth day blood and spinal fluid samples are obtained simultaneously and the bromide level in each case is determined. The normal ratio is between 2.8 and 3.2; a ratio below 2.8 representing increased permeability, and above 3.2 decreased. There are some conflicting opinions but it seems that decreased permeability may be found in about half of schizophrenic subjects and increased permeability in perhaps a third of manic depressive patients. The test is not useful in the presence of chronic alcholism(79) or infectious disease, either of which increases permeability.

Calcium penetration(39, 80) is studied by the simultaneous withdrawal and examination for calcium content of blood and spinal fluid samples; the normal ratio is between 1.8 and 2.2. This test yields the same general result as the bromide test; but abnormalities are not so frequent, nor do they always occur in the same cases as in the bromide test. If either test is to be used, then both should probably be done.

The degree of fall in spinal fluid pressure after the withdrawal of fluid, and the increase in pressure after histamine administration have also been studied(81).

There are a number of other tests which may be applied to spinal fluid which are supposed to be of some value in the diagnosis of these diseases, among which might be mentioned the Weltmann reaction, the Takata-Ara reaction, and the Leymann-Facius test.

While a survey of bacteriological findings has not been a part of this paper, mention should be made of reports of finding by smear or culture the tubercle bacillus in the spinal fluid of schizophrenics(82).

Urinary Findings

In various mental illnesses, especially schizophrenia, there is reported frequency of urination, increased urine output, and a tendency toward low urine urea concentration in twenty-four specimens; however, the results of concentration and dilution tests are normal(83, 84). A frequent acidotic character as demonstrated by the ratio of ammonia nitrogen to urea nitrogen has been reported(84), and in a few instances "unexplained" actonuria may be found(85).

Creatine, normally not present in the urine of men past puberty, but found normally in women and in children and adolescents of both sexes, is said to be present in the urine of male schizophrenics(86). Urinary creatine is also a finding in Grave's disease and in progressive muscular dystrophy. The test is not difficult.

Variations in the levels and ratios of organic and inorganic phosphates in the night urine of manic-depressives have been reported(87).

As in the case of spinal fluid examination there are reports in the literature of several tests of the urine supposed to be specific in various mental diseases. One rather simple

test which is worthy of mention is the Buscaino reaction(88). If to 3 cubic centimeters of urine 1.5 cubic centimeters of 5 per cent silver nitrate be added a white precipitate of silver chloride will form. If this is then heated and agitated for one-half minute no change should take place; but in an appreciable number of schizophrenics and manic-depressives, and in a much smaller number of normal subjects a series of color changes, ending with black, will be observed. The cause of this phenomenon is disputed.

Another frequently mentioned test, the Donaggio reaction(89) is said to be of some value as a guide to the condition and response of patients under shock therapy.

Tests of Liver Function

Abnormal findings in various tests of liver function in schizophrenia have been studied; of these the hippuric acid test(90, 91, 92, 93, 94) and the cephalin flocculation test(95) appear most promising.

The cephalin flocculation test is reported to be positive in slightly less than half of catatonic schizophrenics, and in a higher than normal percent of non-catatonic schizophrenics, especially females.

The hippuric acid test is performed by the administration of 6 grams of sodium benzoate in one ounce of water and examining the urine for the total amount of hippuric acid excreted in four hourly specimens obtained thereafter. The lower limit of normal is 3 grams. Findings markedly below normal seem to be quite common in catatonics and less marked interference with the detoxication of sodium benzoate is to be found in other schizophrenics and in some depressives. There are some studies which are interpreted as failing to confirm the above, but even these show a tendency toward low values in the schizophrenic group.

Oxygen Consumption and Metabolism

Achievement of a true basal state in psychotics is usually impossible, so that in regard to them, the term "basal metabolism" must be interpreted in the light of reality. If the findings of the basal metabolism test in these patients showed a high oxygen consumption they could readily be dismissed as coincident to lack of cooperation. That is not the case. If we accept the normal range as −10 to +10, then we find that half or more of schizophrenics and perhaps a fourth of manic-depressives have subnormal basal metabolic rates(96, 97, 98, 99).

Associated, but more complicated, or less commonly done procedures include the determination of lactic acid, which in schizophrenics(100) is reported to be higher than normal; the mean venous lactic acid for patients being 14.27 milligrams percent and for controls, 10.28 mgm. percent. Reduced and total glutathione are reported(101, 100) as lower in patients with these conditions; 60 percent having been said to show less reduced glutathione than the lower limit of normal. After exercise(102, 103, 32) schizophrenics produce more lactic acid than controls and have a lower blood pH.

Other findings include a tendency toward lower oxygen capacity(104, 105), reduction in hexose phosphates in schizophrenia(106), possible reduction of specific dynamic action of proteins(107), low choline esterase activity(108, 109) in schizophrenia; reduced respiration of certain bacteria in the presence of serum from schizophrenics (100); accelerated Kottman reaction in schizophrenics and delayed in manics(32). The techniques described for determining the sensitivity of the respiratory center to carbon dioxide are quite complicated but a simplified technique might be of some value (103, 110).

For these determinations, as in the case of glucose tolerance, sedation must be avoided.

Miscellaneous Determinations

Abnormalities have been reported in the refractive index and viscosity of serum and in the serum colloids,(32, 89, 111) the latter being studied by means of the ultramicroscope.

The Weltmann coagulation reaction(32, 89) applied to blood consists of adding the blood serum to varying concentrations of calcium chloride and boiling. Calcium chloride coagulates normal serum in dilutions as low as 0.05 percent to 0.04 percent. If dilutions of a greater degree (0.03 percent or less) produce coagulation, it is spoken of

as a shift to the right, and this is reported to occur frequently in schizophrenics and manics.

Hyperostosis frontalis interna(112), as shown by x-ray study, is reported to occur in about one-fourth of female patients (consecutive hospital admissions), and often is not accompanied by the other symptoms and findings of Morel's syndrome.

Studies of vitamin C deficiency and abnormalities in vitamin C tolerance have been made(113, 114, 115).

As was stated in the introduction no attempt has been made to survey completely the literature concerning endocrine imbalance in affective and schizophrenic psychoses at this time. However, mention will be made of a few tests. Menstrual irregularities, especially prolongation of the interval between menstrual periods, sometimes resulting in amenorrhea, are reported to be common in schizophrenics and manic-depressives, and vaginal smear technique in such cases shows, "a tendency to a delay, a weakened expression, or a temporary suppression of the follicular reaction"(116). The biological determination of estrin level by injection into castrate mice of a venous blood emulsion secured 1 to 5 days before menstruation is reported(117) to fail to show demonstrable estrin in more than half of schizophrenics but in less than 10 percent of normal women. Studies have also been made on male sex hormones(4, 118). The amount of cortical hormone, as determined by intraperitoneal injection of blood into adrenalectomized cats, is said to be high in manics(119).

A low amylolytic and high antitryptic titre has been reported in the serum of schizophrenics(120).

There is a phytotoxic property(121, 122) in the serum of depressives which may be demonstrated by its effect on the growth of lupinus albus seedlings.

Abnormalities have been reported in the gastric secretion of patients with these phychoses(123, 124).

Summary and Conclusions

1. Research appearing since 1920 on abnormalities in the results of common laboratory procedures applied to patients with affective and schizophrenic psychoses has been reviewed with the assumption that such abnormalities are occasioned by a variety of factors including the effect of emotion and mood upon various body systems, changes in dietary habits, and changes in activity.

2. It is felt that such information will be helpful in following the course of therapy on patients with these conditions, will assist in differentiating findings due to these psychoses from those of intercurrent disease, and will prevent certain laboratory results from misleading physicians who encounter patients with undiagnosed, early, or borderline affective or schizophrenic psychoses in general hospitals, clinics and private practice.

3. Special attention has been given to abnormalities of the glucose tolerance curve, blood cholesterol level, serum calcium level, leukocyte count, permeability quotient, liver function tests, and basal metabolic rate in these psychoses. In addition, numerous other laboratory tests are discussed.

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PSYCHIATRIC DIAGNOSES OF MILITARY OFFENDERS

CAPT. JEROME M. SCHNECK, M. C., A. U. S.[1]

This paper consists of an outline and discussion of the psychiatric diagnoses of 361 military offenders. These men were studied at a military installation known as a disciplinary barracks of the medium security type. They were examined several months after World War II hostilities had ceased but many of them had been confined while the war was still in progress. Their offenses varied and these will not be discussed except to mention that they consisted of AWOL, desertion, theft, assault, insubordination, inciting riot, rape, and other offenses. AWOL was most common. This series of 361 cases does not comprise all of those seen. Contact had been established with well over 1000 offenders and many more than these 361 had been interviewed so that a diagnosis not encountered in this series may have been met before or after these inmates were seen.

This study is of diagnosis within the general framework outlined in a War Department Technical Bulletin.[2] In the Bulletin an attempt is made to introduce uniformity in nomenclature and a description of the diagnostic categories may be obtained by reference to it. Headings 1 through 5 in Table 1 are taken from the Bulletin. Headings 6 through 9 have been added because of difficulties encountered in classifying all of the offenders according to the nomenclature proposed.

Each diagnosis is based upon information gathered by social worker, psychologist and psychiatrist. The psychiatrist is the last to interview the man and he makes the final diagnosis. The case study consists of a social, educational and occupational history, a civilian criminal and military history, a history of previous military offenses, a story of the present offense and account of adjustment in confinement, a medical survey, psychological tests, and lastly a psychiatric interview. The psychological tests consist routinely of an Army General Classification Test, and occasionally of a Wechsler-Bellevue test, a Minnesota Multiphasic Personality Inventory, a Shipley-Hartford Retreat test, and an improvised sentence completion form.

Some of the offenders were initial cases and others had been interviewed and classified previously. The latter were interviewed at this time for purposes of reclassification. Very many of the previous diagnoses were psychopathic personality, constitutional psychopathic inferiority or constitutional psychopathic state. An impression was gathered that these terms were used exceedingly loosely and covered a multitude of diagnostic groups now listed under the character and behavior disorders in addition to some of the schizophrenias and mental defectives. Many of the cases previously referred to as types of "psychopaths" are included now under the headings of antisocial personality, asocial personality, sexual deviate, addiction and emotional instability reaction. The author believes that a tremendous improvement in nomenclature has been effected by the current classification, especially insofar as eliminating the loose use of the term psychopathic personality; but some question remains regarding the possible retention of the diagnosis for certain cases better understood through a more complete evaluation of the peculiarly defective super-ego structure. This point will not be elaborated here except to state that even so, the diagnosis would be applied to fewer cases than has been the case up to now.

The table requires some explanation. The heading, "character and behavior disorders," has 70 cases noted immediately after it. This indicates that the admixture of traits discovered were such as to make it too difficult to classify the cases under one of the subheadings or else, for other reasons, the subheadings did not seem sufficiently suitable. The total of 232 listed after this group indicates, of course, the 70 cases classified under the generic term plus the remainder scattered through the subheadings. It should be noted,

[1] Branch, U. S. Disciplinary Barracks, Fort Missoula, Montana.

[2] War Department Technical Bulletin (T B MED 203) Nomenclature and Method of Recording Diagnoses, 19 October 1945, War Department, Washington 25, D. C.

TABLE 1

PSYCHIATRIC DIAGNOSES

1. Transient Personality Reactions to Acute or Special Stress:			
Combat Exhaustion	0		
Acute Situational Maladjustment	6		
		Total:	6
2. Psychoneurotic Disorders:			
Anxiety Reaction	6		
Dissociative Reaction	1		
Phobic Reaction	0		
Conversion Reaction	0		
Somatization Reactions	0		
Obsessive-Compulsive Reaction	0		
Hypochondriacal Reaction	0		
Neurotic Depressive Reaction	0		
		Total:	7
3. Character and Behavior Disorders	70		
Pathological Personality Types:			
Schizoid	9		
Paranoid	0		
Cyclothymic	1		
Inadequate	12		
Antisocial	42		
Asocial	8		
Sexual Deviate	5		
Addiction	29		
Immaturity Reactions	2		
Emotional Instability Reaction	5		
Passive-Dependency Reaction	23		
Passive-Aggressive Reaction	12		
Aggressive Reaction	14		
Immaturity with Symptomatic "Habit" Reaction	0		
		Total:	232
4. Disorders of Intelligence:			
Mental Deficiency:			
Mental Deficiency, primary	17		
Mental Deficiency, secondary	0		
Specific Learning Defects	0		
		Total:	17
5. Psychotic Disorders:			
Psychoses Without Known Organic Etiology	2		
Schizophrenic Disorders:			
Schizophrenic Reaction, latent	6		
Schizophrenic Reaction, simple type	2	(1?)	
Schizophrenic Reaction, hebephrenic type	0		
Schizophrenic Reaction, catatonic type	0		
Schizophrenic Reaction, paranoid type	3	(1?)	
Schizophrenic Reaction, unclassified	21	(7?)	
Paranoid Disorders:			
Paranoia	0		
Paranoid State	0		
Affective Disorders:			
Manic-Depressive Reaction	0		
Psychotic Depressive Reaction	0		
Involution Melancholia	0		
Psychoses With Demonstrable Etiology or Associated Structural Changes in the Brain, or Both	0		
		Total:	34
6. Diagnosis Deferred		Total:	46
7. No Diagnosis		Total:	5

TABLE 1—CONTINUED

8. Neurotic Traits	9	
Obsessive	1	
		Total: 10
9. Additional Personality Types:		
Hysterical Personality	1	
Compulsive Personality	2	
Pre-psychotic Personality	1	
		Total: 4
Total		361

likewise, that 2 cases were classified under the general heading of "immaturity reactions" (this designation being in itself a subheading of character and behavior disorders) because they could not be placed under any of the immaturity reaction subheadings. The same explanation applies to the psychoses without known organic etiology.

Attention to heading number 6 ("diagnosis deferred") will show that eventual conclusions as to final diagnostic evaluations would tend to decrease this total and increase the total of some of the other diagnostic headings. Heading number 7 shows a small group with no psychiatric diagnosis. This might possibly be enlarged were some of the diagnosis deferred category to be added to it eventually.

Heading number 8 consists of "neurotic traits." This seemed necessary because the cases could not be classified elsewhere. Of these cases 1 happens to be listed separately under an obsessive category.

Under heading number 9 it seemed necessary to list cases with personality types not recorded elsewhere. These were not appended to the psychoneurotic disorders or character disorders in order to retain the original classification (War Department) intact.

There was some question about making a definite, final diagnosis in certain instances. This is indicated in the table where, under the schizophrenias, the number of cases under a subheading is followed by a number and question mark in parenthesis. Thus, it is equivalent to a "possible" diagnosis. The parenthetical addition is included in the number preceding it when computing the total under the generic heading.

Each case is listed only under one diagnosis and the diagnosis selected was, of course, that into which the case seemed to fit most closely. This was done to avoid complications in computing totals but naturally it is very artificial. In fact, it accounts for some odd results. Thus, it will be noted that no cases are included under the "somatization reactions." Actually there were somatization reactions, mainly gastrointestinal, cardiovascular and genitourinary, but they did not constitute the main diagnosis. Although few cases are listed under the "psychoneurotic disorders" for the reason stated, such disorders were seen in other cases which do not happen to have fallen within this particular series. The "dissociative reaction" listed in the table was a case of somnambulism.

In some instances it was difficult to distinguish between the "antisocial" and "asocial" personalities because of overlapping but, again, they were classified as well as possible under the more appropriate heading. The "sexual deviates" consisted of overt and latent homosexuals with a case of pederasty.

The "addictions" pertain to alcohol. The offenders were listed under this heading when the alcoholism did not appear to be symptomatic of another disorder listed in this nomenclature. Thus, if a man were alcoholic but if the alcoholism were symptomatic of schizophrenia he was listed as a schizophrenic. Cases of symptomatic alcoholism were scattered through many of the diagnostic groups and alcoholism was quite common. There were instances of drug habituation but these usually fell under the antisocial and asocial personality groups.

Another point worth noting is that schizoid features were not infrequent in the offenders diagnosed as asocial and antisocial personalities. Since the latter designations seemed more appropriate they were recorded thus and the schizoid personality group

included only those offenders in whom the schizoid character structure was more pronounced. The author also would not be surprised if, in time, some of the asocial and antisocial personalities show more overt indications of schizophrenic disorders. If the group of schizophrenias in this series seems large it may be accounted for at least in part by the fact that overt delusions and hallucinations were not considered the only criteria for the diagnosis, provided that other indications of schizophrenic thought and affect disturbances were discernible.

The intelligence of many of the offenders appeared low both on psychological testing and in the clinical interview, but in tabulating diagnoses this was given secondary consideration if a personality disorder seemed of foremost importance.

This study of diagnoses cannot, of course, be absolutely fool-proof because of differences in available data and individual differences in examiners who might attempt such a study. It is meant to indicate a trend, however, and with these limitations in mind it is intended as a study in diagnoses within the general framework of the nomenclature outlined by the War Department. It may be of value in a comparative study of diagnoses of military offenders in other military installations and perhaps in civilian penal institutions.

PROCEEDINGS OF SOCIETIES

THE AMERICAN PSYCHIATRIC ASSOCIATION

Proceedings of One Hundred and Third Annual Meeting
Hotel Pennsylvania, New York City
May 19-23, 1947

Monday Morning Session

May 19, 1947

The One Hundred and Third Annual Meeting of The American Psychiatric Association convened at 9.30 o'clock in the Grand Ballroom of the Hotel Pennsylvania, New York City, the President, Dr. Samuel W. Hamilton, of Washington, D. C., presiding.

Chairman Hamilton.—The 103rd annual meeting of the American Psychiatric Association will come to order.

The first item on the program is the introduction of the President-Elect. If there is anyone here who by any chance is not acquainted with Dr. Winfred Overholser of Washington, D. C., please consider that he is now formally introduced to you and he will take the chair.

Chairman Overholser.—*President Hamilton, Fellow Members, and Fellows of the Association:* This premature introduction appears to me to be elicited now for one sole purpose, and that is, to introduce to you the maker of the Presidential Address, Dr. Samuel W. Hamilton. I have now been introduced. He will now speak.

Dr. Hamilton presented his Presidential Address. After he had concluded, the audience arose and applauded.

Chairman Overholser.—*Ladies and Gentlemen:* There is a tradition in the American Psychiatric Association that the Presidential Address is not open to discussion. I shall respect that tradition except for one or two sentences.

In the first place, Dr. Hamilton, I think, has rendered a distinct service in summarizing, in a time of flux when there is much dissatisfaction with things as they are and no hope for the better, what goes on in the Association and how the affairs are conducted. He has indicated that a good deal is done; that a good deal of change has taken place through the years; that the structure of the organization is such that it is amenable to adjustment, to the needs of further changes in the situation. He has done well to call our attention, too, to the background of the difficulties which beset the institutions, and indeed, the whole practice of psychiatry.

For all of this I am sure we are grateful and I wish, on behalf of the Association, to express what I am sure you feel: our gratitude to Dr. Hamilton for this valuable summary of the past and the vision of the future.

Chairman Hamilton.—I thank you all.

We now have the pleasant privilege of listening to our colleague, Dr. G. Brock Chisholm. He is Executive Secretary of the Interim Commission of the World Health Organization, and he will talk to us about The Future of Psychiatry.

Dr. Chisholm.—*Mr. President, Ladies, and Gentlemen:* May I thank you most sincerely for giving me an opportunity to speak to you. You will appreciate, of course, that what I have to say is from the point of view of international interest. But when I speak of the future of psychiatry, I speak about the organization of it in relation to the world as a whole and not to any one part of it. I would like that clearly understood because I may leave out of consideration many things that are of national importance.

Dr. Chisholm presented his address and when he had concluded the audience arose and applauded.

Chairman Hamilton.—Dr. Chisholm needs no formal words from me of appreciation for what he has said to you. There will not be a general discussion of this paper. We might give the whole meeting of the Association with not four but six or eight or ten sessions to a discussion of various phases of it, and have a week filled.

We are fortunate at this session in having with us our colleague from England, Dr. John Rawlings Rees. He is going to speak to us more at length Wednesday evening, but since the program of next year's Congress is primary among the many responsibilities that he carries, he will speak to us for a few minutes now in elaborating some phases of what Dr. Chisholm has said.

Dr. Rees.—*Mr. President, Ladies, and Gentlemen:* I cannot tell you how much I welcome the opportunity of saying a word here, being first of all in this great country and then meeting this great Association.

Dr. Chisholm has certainly put fairly and squarely in our laps this problem of mental health for the future and I need advance no arguments as to the importance of what we have some little while been

trying to do. I do ask particularly today for your interest because, perhaps during the course of this conference and meeting, there may be an opportunity for you to give your criticism and your suggestions about this particular Congress.

There are on the reception desk the preliminary brochures which have just arrived, which will give you the outline of the Congress as proposed, and of the program. We do want, we depend, indeed we must have active cooperation from this group over here in the A.P.A. because without it we certainly could not make this International Congress mean very much.

The origin of the Congress really was this: That the European countries, the countries that had been occupied, were, of course, feeling desperately cut off from everything that was happening, desperately aware of the problems that Dr. Chisholm has just been talking about. They asked for congresses and meetings to be arranged in England, and so last year, discussing it with some of you over here, it was arranged that we should hold what would be the Third International Congress on Mental Hygiene and we should combine with it two other rather more technical conferences, that on Child Psychiatry, their second, and a Congress on Psychotherapy, which is another European association or federation. We have combined these, as you will see in the program, and I would hope to get your very frank criticisms. I hope you will shoot us down in ribbons, as they say in the Air Force, if you do not like it, and let us know about it so that we can return to England to the Program Committee to tell them about it.

We puzzled a great deal as to how to make an International Congress effective; how, when we will have Chinese, East Indians, Russians, British, Scotchmen and all sorts of people talking different languages or dialects, how we are going to make it succeed in a very short time. Can it be done by a whole lot of individual papers that everybody can listen to?

Well, we thought not. I don't know what you will think but we have been somewhat revolutionary and we have decided that through the whole of that Congress, both in the technical groups and in the more general group, no one is going to express an individual opinion in a paper; that everybody who reads a paper is going to be reading the result of group discussion beforehand, and we hope that every speaker on this topic of guilt, for example, which the psychotherapeutic group on the Continent have chosen, will insist that everybody will have discussed this with a large and diverse body of his colleagues, not only in psychiatry but in other disciplines as well, and that when he presents the opinions, they will be the opinions of group discussants. We can in that way afford to have fewer speakers and omit a good many things. We are trying to streamline the program as much as we possibly can.

The main conference of the Mental Hygiene group, the larger part of this whole Congress on Mental Health, we have called Mental Health and World Citizenship. We had, in fact, quite early the idea that we could do something to support the remarkable charter of the World Health Organization and so we have chosen, as you will see in the program, as our five days of main topics, the problem of world citizenship and good group relationships, the individual in society, family problems and psychological disturbances, planning for mental health, organization, training, propaganda, and mental health in industry and industrial relations.

We want to get the whole work of this Congress done before the Congress ever happens, if possible, because I think then we shall really do some further good work in the bars, if we can find them in London, which is where most of the work of the Congress takes place. The only way we can get this done is to get these subjects adequately discussed, and so we have set up preparatory commissions, separate groups for each of the topics of these five days, groups that we have designed for their basic structure to have a psychiatrist, a psychologist, a social scientist, an educational or business man or whatever it may be, an economist and an anthropologist. We have started these central groups in London and they have already begun studying all the material that might conceivably come under the heading of their particular topics.

We hope to have the other groups working in Scotland because we have chosen Londoners for these central groups. We hope to get them started in Canada and a great many in the United States. We are going to set them up in Switzerland and Holland and Scandinavia and further still afield, and we want these groups to meet and to let us know when they are meeting, when such groups are established, to keep in touch with the central group in London, who will then circularize repeatedly, constantly, all the other groups and tell them the sort of material that is coming in, the general trend of thought, the kind of books, the kind of papers that are worth reading. We want to hammer out these subjects and make sure they are presented to the larger world outside as the result of this Congress.

We have told the groups in London, the preparatory commissions, as we have called them, that we want, if possible, to arrive at some universally agreed matters which can be put in the form of resolutions to the World Health Organization at the end of that Congress in London.

And so what I want, and I know I don't ask this sort of thing in vain in this Association, is to see university groups, mental hygiene societies, and other groups of this sort being started right away. We do not have very long. If we can get enough mixed groups approaching it from every angle, working on each of these topics, then we shall indeed have done much of the work of the Congress beforehand and we ought to be able, when we get to London, to go a stage further in international relations.

We propose that those who have been working in groups in their own countries, when they get to London, shall begin to spend part of the mornings of the Congress in groups, but this time not with their own buddies. They should find themselves in groups of ten with representatives from

other countries and there will be the need to hammer out some of the international difficulties, differences of ideology, of terminology and so on, and get some real agreement. It will, we hope, be an experiment in international relationships in getting international agreement. We have a committee working on the structure and method of this Congress.

In addition to London, we also have a further group which is quite apart from the subjects that you will see suggested in the program. We have a group working on the dynamics of social change, hoping they will arrive at some practical conclusions and be able to tell us what we can do when they have reached these conclusions, how we can affect public opinion, how we can affect governmental opinion, how we can make something happen as the result of what we as a group feel might well be done.

So that is all I want to say to you today, ladies and gentlemen. I hope you will get these preliminary brochures which are outside. I hope that you will give it some time and thought. I hope that you will give me all sorts of suggestions, ideas and so on, while I am here. Dr. Fremont-Smith and I will collect and collate these various ideas and suggestions. Please do not feel that if you disapprove you should not tell us. Those are things I want to know and take back to England, criticisms and suggestions and the real impression of this, the largest group of psychiatrists in the world. Thank you so much.

CHAIRMAN HAMILTON.—We are happy to have this presentation of the big project that is ahead for next year at this time.,

Will Dr. Parsons come forward and make a report for the Committee on Arrangements?

DR. PARSONS.—*Ladies and Gentlemen:* The Committee on Arrangements has been especially set up by the officers of this Association for your convenience and comfort and for the entertainment of your ladies. The Committee anticipates that most of the men members will find their entertainment between the covers of the program, and but little has been planned for them.

Members will be welcomed this evening, admission by badge let me say, between six and seven P.M. at a cocktail party. The hours will be strictly adhered to and, I repeat, admission will be by badge.

In the vicinity of New York, there is much of psychiatric interest. Institutions and clinics are open to you and you are especially invited to the Payne-Whitney Clinic at the foot of East 68th Street. For those who have a special interest in schooling and juvenile delinquency, I shall have occasion later to make a special announcement.

For us there is an interesting program. Having had nothing to do with it myself, I may be permitted to say it is the best ever. The Council has provided for the Women's Division of the Committee on Arrangements a special rendezvous, at which place the ladies will find gracious and good-looking hostesses to advise them how to spend the time pleasantly and profitably. To all ladies and gentlemen, the Committee on Arrangements hopes that when the unhappy time for your departure comes, you will go away regretfully.

CHAIRMAN HAMILTON.—Thank you, Chairman Parsons.

Dr. Malamud, will you report for the Committee on Program?

DR. MALAMUD.—*Mr. President, Ladies, and Gentlemen,* the program as printed is, I hope, before you all, and there is very little that I have to add to it. There are a few changes that we felt had to be made after the program was set up and one of the most important ones is one that I want to mention right now.

This afternoon at two o'clock we had scheduled Section II, the program of Experimental Studies. We had to change that. You have a notice to that effect on the back of the first page and also at the beginning of this morning's program. Section II, therefore, instead of the Experimental Studies, will be a meeting of the Joint Session of the American Psychoanalytic and American Psychiatric Associations. That will be up in the Penn Top.

There are a few minor changes in regard to papers that had to be shifted, but those will be announced at each of the Sections by the chairman.

The Committee and, I am sure, the President, are very eager to have the meetings take place sharply on time and according to schedule. The chairmen of the various sessions will please start their meetings at exactly the time when they are supposed to. Members of the Program Committee will be available if anything happens, such as if one of the chairmen cannot be at a session, and they will start the meeting. It is very important for those of you who are presenting papers to please hold to your time limits. The Chairman will try and do that, but it is much more pleasant for the essayist as well as for the chairman to have the man who reads the paper watch his time himself.

CHAIRMAN HAMILTON.—There are a couple of misprints in the program. The Chairman of Section III on Wednesday morning will be Dr. James Watson.

The Chairman of the program on Psychopathology on Thursday morning will be Dr. John G. Lynn, IV.

Now the report of the Secretary-Treasurer.

DR. BARTEMEIER.—I have first an announcement to give you, a message from our distinguished colleague in Mexico, Dr. Samuel Ramirez Moreno. Dr. Moreno wires us as follows: "In the name of the Secretary of Public Health and Assistance of Mexico and in my own, I want to express our wishes for the success of this annual meeting in its benefit to science and to your patients. Sincerely yours, Dr. Samuel Ramirez Moreno."

I have two requests: Will the chairmen of the Sections kindly give me the names of the newly elected officers of the Sections so that they may be announced during the course of our meeting on Friday?

I have also been requested to announce that the Membership Committee will meet with Dr. Ackerly

for a brief special meeting at twelve o'clock noon today in Room 1148.

There will also be a meeting of the Committee on Legal Aspects of Psychiatry at two o'clock today in Conference Room No. 3 on the ballroom floor. So much for announcements.

It is my pleasure to give you the following report regarding our membership as of April 1, 1947:

We had a total membership in our Association of 3,972 as of April 1, 1947. This represents a net increase in our membership of 338 members during the past year. Our membership has more than doubled in the past ten years. The breakdown of the total membership is as follows: We have 19 honorary members, 98 life members, 18 corresponding members, 935 Fellows, 2,485 members and 417 associate members, a total of 3,972 members of the Association as of April 1st of this year.

I will now give you a brief summary of our financial situation for the period from April 1, 1946, to March 31, 1947. This is the auditor's report.

The income from our general account amounted to $34,742.65. The income from the JOURNAL account amounted to $13,815.65. The income from the annual meeting in 1946 amounted to $13,184.15. The total income to the Association from these three sources—the general account, the JOURNAL, and the annual meeting—amounted to $61,742.45.

With regard to the expenses: The expenses from the general account amounted to $33,503.02. The expenses connected with the AMERICAN JOURNAL OF PSYCHIATRY amounted to $17,723.53. The expenses in connection with the annual meeting in Chicago amounted to $13,188.98, so that our total expenses during the past fiscal year amounted to $64,415.53 and our total income was $61,742.45. Our deficit for the last year was $2,673.08.

Now a recapitulation of all our resources: We have a total cash balance on hand of $22,099.16. Our net resources including this $22,099.16, together with United States government bonds, Canadian government bonds, meeting account and the AMERICAN JOURNAL OF PSYCHIATRY account, in the Chase National Bank, amount to $42,747.68.

CHAIRMAN HAMILTON.—This report has been acted on by the Council and is brought you for your information. In due time you will be called on to corroborate and approve all the acts of the Council, so you will approve this indirectly unless you find some errors meanwhile.

The Committee on Resolutions will be as follows: Chairman, Dr. Harry A. Steckel of New York, Dr. Carl J. Hedin of Maine, Dr. Edwin E. McNiel of California, Dr. Charles G. Stogdill of Ontario, and Dr. Charles A. Zeller of Michigan. I ask that all the members of the Committee report to Dr. Steckel as soon as they can and he will inform them when the meeting of the Committee will be held.

One of the serious and more saddening moments of the annual meetings, as time goes on, is when we pay respect to the memory of our deceased colleagues. Father Kelly, one of our two Fellows who are also clergymen, was to have pronounced the benediction. He has wired us that, owing to injuries from an automobile accident, he will not be able to be here. We have sent a proper telegram of sympathy to Father Kelly.

The Secretary will read the list of deceased members. During that reading the audience will rise. At the end, I will read you a part of Father Kelly's telegram. I will ask you to stand for a moment after that in silence and will give you a signal by the gavel to resume your seats.

While the audience stood, Dr. Bartemeier read the list of the deceased members as follows:

G. G. Kineon, Gallipolis, Ohio, died Aug. 21, 1943.

A. Whitefield Hawkes, New York, N. Y., died Dec. 17, 1943.

A. W. Foertmeyer, Cincinnati, Ohio, died Jan. 24, 1943.

Elmer N. Carter, Huntington, W. Va., died June 19, 1944.

Orland R. Blair, Clarks Summit, Pa., died Oct. 21, 1944.

S. Stanley King, New Rochelle, N. Y., died Jan. 10, 1945.

William W. Richardson, Mercer, Pa., died June 19, 1945.

James W. MacNeill, N. Battleford, Canada, died July 1, 1945.

Clifford B. Howard, Ogdensburg, N. Y., died Aug. 10, 1945.

George J. Wright, Pittsburgh, Pa., died Oct. 1, 1945.

Robert M. Elliott, Canandaigua, N. Y., died Oct. 5, 1945.

C. E. Shinkle, Cincinnati, Ohio, died Oct. 5, 1945.

Gomer S. Llewellyn, Mayview, Pa., died Nov. 21, 1945.

Arthur J. White, Scranton, Pa., died Nov. 21, 1945.

Benjamin Warren Black, Oakland, Cal., died Dec. 1, 1945.

Arthur E. Pattrell, Baltimore, Md., died Dec. 17, 1945.

Frank S. Rankin, Chicago, Ill., died Dec. 21, 1945.

T. B. Bass, Abilene, Tex., died Dec. 22, 1945.

Lorne W. Yule, Columbus, Ohio, died Feb. 17, 1946.

Michael F. Lonergan, New York, N. Y., died Mar. 7, 1946.

Leo Wolfson, Poughkeepsie, N. Y., died Mar. 15, 1946.

Walter S. Jensen, Washington, D. C., died Apr. 4, 1946.

Daniel Plouffe, Montreal, Canada, died Apr. 6, 1946.

Shelton G. Silverburg, Evansville, Ind., died Apr. 6, 1946.

Earle V. Gray, Helmuth, N. Y., died Apr. 21, 1946.

Thomas P. Prout, Summit, N. J., died Apr. 26, 1946.

Miner H. A. Evans, Boston, Mass., died May 5, 1946.

Jacob Kasanin, San Francisco, Cal., died May 5, 1946.

Bruno Daniel, Ward's Island, N. Y., died May 21, 1946.

Blakely R. Webster, Plattsburg, N. Y., died Sept. 5, 1946.

Lilla Ridout, Bryn Mawr, Pa., died June 27, 1946.

Glenn S. Weaver, Big Springs, Tex., died May 10, 1946.

Norman G. Tufford, Detroit, Mich., died Aug. 10, 1946.

James E. Smith, Petersburg, Va., died Aug. 15, 1946.

Florence Chapman, Akron, Ohio, died Sept. 10, 1946.

Louis Malinash, Brooklyn, N. Y., died Sept. 20, 1946.

Christopher C. Beling, Newark, N. J., died Dec. 1, 1946.

Walter Schilling, San Francisco, Cal., died Dec. 16, 1946.

Edouard Toulouse, Paris, France, died Jan. 19, 1947.

Arthur S. Pendleton, Raleigh, N. C., died Jan. 26, 1947.

Clara Louise McCord, Philadelphia, Pa., died Feb. 8, 1947.

Mary J. Walters, Atlanta, Ga., died Mar. 7, 1947.

CHAIRMAN HAMILTON.—"May God be with you and all my colleagues of the Association in your deliberations and in your continuing to be sound leaders of our most important profession. May the deceased members whose names you read receive from Him their deserved reward for devotion to the afflicted. May they rest in peace."

There will be a meeting of the Council at 3.30 in Conference Room No. 2 where it met yesterday and the day before. The Council are informed of this, but any representatives of Affiliate Societies who have come in this morning will recall that their presence is not only welcome but sought.

The session adjourned at 11.30 a.m.

TUESDAY MORNING SESSION

MAY 20, 1947

The general session of the American Psychiatric Association convened at 9.00 o'clock in the Grand Ballroom of the Hotel Pennsylvania, Dr. Samuel W. Hamilton presiding.

PRESIDENT HAMILTON.—The meeting will come to order. Gentlemen, the Chairman of the Nominating Committee, Dr. Earl D. Bond, will report.

DR. BOND.—*Mr. President, Ladies, and Gentlemen:* The Nominating Committee presents a unanimous report. It was convinced that at last year's meeting the Association showed that it wanted to have an Association vote on many of its officers.

The Committee commenced the discussion of nominating machinery, as an experiment, the balloting of which will be held today, and for the good of the Association, three outstanding men have allowed their names to go on the ballot for President-Elect for 1947 and 1948. All these men deserve the sincere thanks of the Association. The Committee nominates for President-Elect Dr. Nolan D. C. Lewis, of New York; Dr. William C. Menninger, of Kansas, and Dr. Arthur P. Noyes, of Pennsylvania.

For three Councillors, the Committee proposes the following: Dr. William Malamud, of Massachusetts; Dr. Mesrop A. Tarumianz, of Delaware; Dr. George S. Johnson, of California; Dr. Robert H. Felix, of the District of Columbia, and Dr. Frank H. Luton, of Tennessee.

You will notice that two names have been omitted from the printed ballot. One of these is Dr. John Romano. His name is withdrawn at his request for reasons acceptable to the Committee. The other name is that of Dr. Donald W. Hastings, whose name is withdrawn because he will not become a Fellow at this meeting, as was expected.

The Committee was asked by the Council to make nominations for the office of Treasurer separate from that of Secretary, and so it recommends, for Secretary, Dr. Leo H. Bartemeier of Michigan; and, for Treasurer, Dr. Howard W. Potter of New York.

For Auditor, the Committee recommends Dr. Conrad S. Sommer of Illinois.

CHAIRMAN HAMILTON.—You have read the report, gentlemen, are there any objections?

In the absence of objections, the report is accepted, and nominations are in order from the floor. Are there nominations for the office of President-Elect?

Hearing none, the Chair will proceed. Are there any nominations for the office of Secretary?

Are there any nominations for the office of Treasurer? Are there any nominations for the office of Councillor?

On motion by Dr. Charles Englander, seconded by Dr. Spafford Ackerly, it was voted to close the nominations.

CHAIRMAN HAMILTON.—Ballot boxes have been placed in the polling booth near the registration desk. The polls are open from nine o'clock until four.

The Board of Tellers will consist of the following: Dr. Marion R. King, of the District of Columbia; Dr. Melvin J. Rowe, of California; Dr. Newton J. T. Bigelow, of New York; Dr. Coyt Ham, of South Carolina; Dr. Louis V. J. Lopez, of Colorado; and Dr. Sidney G. Chalk, of Ontario. Those Tellers who have not seen Dr. King will please report to him. Dr. King is Chief Teller.

The Chair knows of no other business to take up at this time. The Tellers will have a long job, and I would ask that you make their work as convenient as you can, please. The Chair will be avail-

able in the late afternoon to hear the announcement of the vote. It is not planned to call the Association together for that purpose, although we will pass the word around.

Members and Fellows are entitled to vote.

The Tellers will proceed to the registration room and commence their duties. They will be ready to receive you all there in a very few minutes.

We have printed ballots with the names of the nominees that were read to you, and which also contain two names which you can disregard or strike off, together with space for writing in other names. However, since no other nominations have been made, that space is unnecessary at the present time.

Gentlemen, our constitution says that the President-Elect shall succeed to the Presidency at the end of the Convention session. It says that the retiring President shall become Councillor. It also says, in another place, that all the officers shall be elected.

Unless there be objection from the floor, the Chair directs the Secretary to cast a ballot for the President-Elect to become President, and for the out-going President to become Councillor.

Hearing no objection, we will do it that way. The constitution does not intend to have any conflicting areas, but I thought we would do this so our records will be all straight. You see, we are a corporation, incorporated under the laws of the District of Columbia.

I believe I have spoken long enough now and that the Tellers are ready. The session, therefore, is adjourned.

Before you leave, let me remind you of another thing: It is strongly, urgently requested that you obtain your tickets both for the round table meetings and the banquet today, instead of waiting until tomorrow, when some late-comers will be in and wanting to get to the booth. Please buy all the tickets that you are going to want, if you have now made up your mind about them, today. The balloting will proceed.

The session adjourned at 10.00 a.m.

Wednesday Morning Session

May 21 1947

The business meeting of the American Psychiatric Association convened at 9.00 o'clock in the Grand Ballroom of the Hotel Pennsylvania, New York City, New York, Dr. Samuel W. Hamilton presiding.

President Hamilton.—The meeting will come to order. Some business comes over from yesterday. Our Tellers were busy until 8.00 o'clock last night. At this time, before their announcement, I wish to convey the thanks of the Association to them, and also to the two ladies who served as poll clerks, for their earnest, intelligent, and very faithful attention to their duties.

The chief teller, Dr. Marion R. King, will present the report of the election.

Dr. King.—The number of ballots and the number of votes cast during the annual election of May 20, 1947 are as follows: Total number of ballots, 562; total number of votes for candidates listed on the printed ballots for President-Elect, Dr. Nolan D. C. Lewis, 198; Dr. William C. Menninger, 230; Dr. Arthur P. Noyes, 133.

For Secretary, Dr. Leo H. Bartemeier, 519. For Treasurer, Dr. Howard W. Potter, 506. For Councillors, Dr. Robert H. Felix, 388; Dr. George S. Johnson, 281; Dr. Frank H. Luton, 170; Dr. William Malamud, 399, Dr. Mesrop A. Tarumianz, 252. For Auditor, Dr. Conrad S. Sommer, 467.

There were also a total of twenty names written in the blank spaces on the ballots by the voters: one name with one vote for president-elect, two names with one vote each for secretary, two names with one vote each for treasurer, thirteen names with a total of forty-nine votes for councillors and two names with one vote each for auditor.

The final results of the election are as follows: Elected for president-elect, Dr. William C. Menninger; for secretary, Dr. Leo H. Bartemeier; for treasurer, Dr. Howard W. Potter; for councillors, Dr. William Malamud, Dr. Robert H. Felix, and Dr. George S. Johnson; for auditor, Dr. Conrad S. Sommer.

President Hamilton.—Let me call your attention to the fact that the auditors have also given us a very careful report. In the absence of objection on constitutional or other grounds, I declare these gentlement elected: William C. Menninger, Leo H. Bartemeier, Howard W. Potter, William Malamud, Robert H. Felix, George S. Johnson, and Conrad S. Sommer to the respective offices for which they were nominated.

There will be a meeting of the Council this afternoon immediately following the session. The newly elected councillors take office immediately upon election.

I would like to say a word to the assembly about our retiring councillors. It has been a great privilege to serve with this Council. Those going off include Dr. Waggoner, who brings to us the experience and the valuable teaching ability that come from a great university; Dr. George Alexander Young, an admirable example of urbanity and effectiveness, of what the private practitioner can be, and now that some of the younger private practitioners are finding voice they may well look to what has been done in the Omaha region, which is in no small measure the result of the activities of a private practitioner; Dr. Thomas A. Ratliff, a fine outspoken representative of the progressive group, and Dr. Arthur H. Ruggles, previously secretary, president-elect, and president of this organization and upon whom has fallen in no small measure the mantle of the late Thomas W. Salmon. When there are difficulties and when there are conflicting views to be reconciled and when there are personal tangles that need to be untangled, there is no one more valuable to this Association and his colleagues than Dr. Ruggles.

The secretary will read to you a constitutional

amendment which was duly noted to you a year ago and has been printed in the JOURNAL.

DR. BARTEMEIER.—As printed in the JOURNAL in the January issue of the present year: "Notice to members of the American Psychiatric Association: In accordance with the provisions of Article 8 of the constitution of the Association and in accordance with the vote of Council, notification is hereby given that at the 1947 meeting the following amendments proposed by the Committee on Membership will be presented for vote:

"Strike out Article 3 Section 5 and insert the following in its place: Section 5—Members hereafter shall be chosen from physicians who have specialized in the practice of psychiatry for at least three years and after fulfilling the requirements of associate members. Members shall be recommended to fellowship as it becomes apparent that they deserve this recognition.

"Amend Article 3 Section 6 to read as follows: Section 6—Associate members shall be physicians who have had at least one year's practice in a mental hospital or its equivalent."

PRESIDENT HAMILTON.—In my opinion, the essence of this is that it is a little harder for us to elect as a member a person who has not had hospital experience. One of our quite prominent members who addressed you Monday would have been a little harder to elect as a member when he was elected two or three years ago, under the constitution if amended in accordance with these recommendations.

The proponent of the amendments is Dr. Ackerly and I will ask him to come to the rostrum and explain to you why he and the committee think that this further restriction should be made.

DR. ACKERLY: May I read the section of the constitution, Article 3 under membership as it now stands? That is, concerning these two sections. Section 4, Article 3, now reads: "Associate members shall be physicians who have had at least one year's practice in a mental hospital." Section 5 reads as follows: "Members hereafter shall be chosen from physicians who have specialized in the practice of psychiatry for at least three years." Now it seemed to the Committee on Membership that this Association would wish to have on record in the constitution some requirement whereby a member must have some experience in a mental hospital or its equivalent. It was felt by the Committee that this new wording would put the American Psychiatric Association on record as favoring one year's practice in a mental hospital for members as well as associate members and, at the same time, keep the meaning of the articles of this Association broad enough not to exclude any desirable member.

These amendments were adopted on motion by Dr. Ackerly, which was seconded by Dr. Ruggles.

PRESIDENT HAMILTON.—The Secretary will inform you of some amendments proposed for action next year.

DR. BARTEMEIER.—The following amendments are proposed by Dr. Samuel W. Hamilton in a communication to me dated February 10, 1947: "Dear Doctor: Please be informed that the following amendment to Article 6 of the constitution and two amendments to Article 7 are respectfully proposed for action at our annual meeting next year." (That is, 1948).

"Article 6: Add as follows, Section 4: The Council may fill vacancies occurring among elected officers. Article 7, strike out the words 'or Council.'"

May I read this first article? In article 7 under "powers" our present constitution states, "The president shall preside at the annual and special meetings of the Association or Council." Now the proposed amendment is to strike out "Or Council."

The additional amendment that is proposed is that "the Council shall choose annually a fellow of the Association as moderator to preside at all its sessions. In case the moderator be not a member of the Council he shall have no vote."

Then Dr. Hamilton adds: "It may be remarked that these amendments have been discussed informally with councillors and others for two years and the present form is the result of such deliberations."

PRESIDENT HAMILTON.—I mentioned these matters in my report to you Monday. Perhaps sometime during the year I shall bring the subject up again. They have been modified from the original wording that was proposed by me.

I sponsor them with entire satisfaction in their present form, and no discussion is necessary now because you have a year to think about that.

The next order of business is the election of members. The Secretary will inform you about the recommendations of the Council.

DR. BARTEMEIER.—The acts of the Council at its December meeting on December 14-15, 1946 have already been distributed.

The Council recommends for election to associate membership a total of 95 names. For reinstatement as an associate member, one; for election to membership, 356; reinstatement as members, seven; transfer from associate member to member, 194; transfer from member to fellow, 75; reinstatement as a fellow, two; corresponding member, two; honorary member, two. The second one is Dr. J. R. Rees of London.

PRESIDENT HAMILTON.—If the Association wishes, these names will be read to you individually, but you have them before you with the exception of the last name, Dr. John Rawlings Rees who is well known to you, whom you heard Monday, and whom you will hear tonight.

Dr. Rubenstein moved that the secretary cast a ballot for the election of these persons in their respective classes and the reinstatement of certain ones who have formerly been

members. Dr. Heldt seconded the motion and it was carried.

PRESIDENT HAMILTON.—I would like to inform you of the presence of several persons from abroad, in addition to those whom you have already seen and perhaps heard: Dr. Baron from the Argentine, and if he is in the audience at the moment we would appreciate his standing but I don't think he is here this morning; Dr. O'Reilly of Birmingham, England, and Dr. Sargent of England; Mrs. Gillespie, the widow of our former honorary member, R. D. Gillespie.

The Secretary will give you the report of the Council.

DR. BARTEMEIER.—Upon the request of the Maryland Association of Private Practicing Psychiatrists supported by the opinions of 899 fellows and members, the Council recommends the establishment of a Section for this group.

The New York Society for Clinical Psychiatry has applied to become an affiliate society. A copy of its constitution and bylaws, together with a list of its members, has been filed and the Council recommends that the society be accepted.

It has been voted to accept a gift of $25,000 from the estate of the late Lt. Lester N. Hofheimer to establish an annual prize of $1,500 for eighteen years for distinguished research contributions to psychiatry. A self-perpetuating board composed of fellows and members, one of whom will be the president ex-officio, will award this prize at annual meetings of this Association.

The membership dues of Dr. John F. Norris have been remitted until he resumes practice.

The Council voted to revise the wording of the membership certificate and the fellowship obligation.

Telegrams have been sent to the chairmen of the House Committee on Veterans Affairs and the Committee on Appropriations in the House and Senate, urging that the appropriations for the Neuropsychiatric Division of the Veterans Administration be increased in order to maintain high standards of medical care for veterans.

Dr. C. C. Burlingame has been delegated to represent the Association at coming meetings of the Royal Medico-Psychological Association and the Netherlands Psychiatric Society.

It has been voted to send a copy of the report of the Committee on Psychiatric Social Work to the superintendents and medical directors of mental hospitals in the United States and Canada.

One dollar from the dues of each fellow and member is to be allotted to the JOURNAL account.

The Council decided that within sixty days prior to the annual Council meeting, the Committee on Membership shall distribute to Council their approved list for all classes of membership.

An appropriation of $1,500 was voted to the Committee on Psychiatry in Medical Education.

A special committee will be appointed to draw up a statement of psychiatric principles and practice.

Upon the recommendation of the Committee on Standards and Policies, it was voted to create a Board for the rating of mental hospitals, the funds to be obtained elsewhere.

A re-issue of the centenary volume in a cheaper edition is approved for publication.

The Secretary has been instructed to send notes of regret at the absence from its meeting of the following four past-presidents of the Association: Drs. Adolf Meyer, Clarence O. Cheney, James V. May, and C. Fred Williams.

Questions having been raised about certification of psychiatrists working in institutions for mental defectives, the problem was referred to the Committee on Standards and Policies for consideration, and Dr. Bowman was delegated to confer with the American Board of Neurology and Psychiatry about the matter.

The Council voted that the Executive Committee investigate the desirability of our securing membership in the Social Science Research Council.

The Association will pay $75 to the American Registry of Pathology as its share of the expense of the preparation and distribution of pathological slides.

The Council approved the recommendation of the Executive Committee that the Thursday morning session be considered a meeting of The Committee of the Whole.

On motion by Dr. Sandy, seconded by Dr. Ackerly, the report of the Council was voted accepted and approved.

PRESIDENT HAMILTON.—Some of these matters will receive further comment in the JOURNAL. You can see that some of them bring us great gratification and others are knotty problems that we report to you because we are endeavoring to untangle them.

Will Dr. Burkes come forward? I had the pleasure on Dr. Overholser's nomination of appointing Dr. Burkes of Portland, Oregon, Chairman of the Committee on Arrangements for next year's meeting.

He is here and desires to say something, although I don't know whether he will talk about the climate or roses or what else, but he wants to say something about the relation of this Association to Portland, Oregon, in 1948.

DR. BURKES.—I shall omit speaking about the weather. This year we had the most perfect weather that I have ever known since I have been in Portland, and next year we can promise you nothing so far as the weather is concerned. However, the Weather Bureau informed me that for this same period in the past 40 years the average rainfall has been 20 one-hundredths of an inch for those 5 days. This may help some.

The hotel situation in Portland is adequate, we feel, to handle this crowd. We have in the twelve leading hotels, a total of 2,700 hundred rooms and we have been promised 850 double rooms and some 2,300 single rooms. That has been assured us.

We may have more at that time than these 12 more acceptable hotels. To relieve some anxiety

about this, I might state that the American Medical Association met in Portland in 1929 and the crowd was handled adequately; and a few years later the American Legion met there with a much larger number; and this coming July the Elks Convention will be held in Portland, and they anticipate somewhere in the neighborhood of some 30-40,000 people.

The medical activities, including the scientific and commercial exhibits and all the things pertaining to the scientific programs, will be held in the Masonic Temple. It is centrally located and is only half a block to 2 or 3 blocks from a number of the hotels and only some 8 or 10 blocks from the hotel which is the farthest away.

The ballroom floor, which is on the ground floor, we have reserved for the exhibits. We have there some 6,100 square feet of space that can be used in addition to many square feet on the promenade that extends the full length of the auditorium on two sides and one end. The room on the second floor will seat some 5-600 and there are three other rooms that will seat 250 each. On the third floor, the Shrine Hall can seat 1,700 people. There are a number of smaller rooms available in addition to one dining room that will seat up to 300.

All activities not pertaining to the scientific program will be held at the Multnoman Hotel. The banquet and many of the dinners and perhaps the round table discussions could be held at the Masonic Temple if it were not for the meals, but we have ample space and some to spare in the Multnoman Hotel to take care of that activity.

We are very happy and feel quite honored to have Portland accepted as the host city for the coming convention and we shall try to see that none of you who might attend are disappointed.

PRESIDENT HAMILTON.—If it turns out that any of our membership will be in England or Holland this summer, we shall be happy to designate additional delegates to the annual meetings of our sister associations in those countries. If any of you decide to make that trip, please be so good as to inform the secretary.

It would be a convenience at the present time if someone would move ratification of the acts of Council and the Executive Committee taken since the last annual meeting. Would someone care to do that? This being a corporation it is well to have that kind of a motion on the record every year.

Dr. Dunton moved that the acts of Council and the Executive Committee taken since the last annual meeting be ratified. Dr. Stevenson seconded the motion and it was carried.

PRESIDENT HAMILTON.—Let me announce again, please, that immediately after the afternoon session the Council will meet in Parlor A, and those gentlemen who are newly elected will report for duty. Please get your tickets for tonight's banquet as soon as you possibly can. There will be a goodly number and we would like to have a complete check, if possible, because it will aid the management. We will now have the report of the auditors.

DR. BARTEMEIER.—This report is for the period from April 1, 1946, to March 31, 1947:

INCOME

Income—General Account:		
Membership Dues		
Back Dues	$1,969.50	
1948-49	1.00	
1947-48	184.66	
1946-47	28,677.00	
Refund—Annual Meeting	1,700.00	
Fellowship Certificates	295.00	
Membership Certificates	66.00	
Biographical Directory	2.75	
Rent—Committee Psychiatric Nursing	700.00	
Rent—AMERICAN JOURNAL OF PSYCHIATRY	300.00	
Interest—Savings Account and Bonds	754.70	
Insurance Refund	92.04	
Total Income—General Account		$34,742.65
Income—AMERICAN JOURNAL PSYCHIATRY:		
Advertising	$5,527.52	
Subscriptions	7,919.76	
Back Numbers	290.28	
Miscellaneous	78.09	
Total Income—JOURNAL Account		13,815.65
Income—Annual Meeting—1946		
Commercial Exhibits	$6,630.00	
Banquet Gifts $500. (Abbott Labs., $300. Chicago Neurological Society, $200.) Tickets, $3,324.00	3,824.00	
Carried forward	$10,454.00	

Brought forward	$10,454.00	
Cocktail Party (Committee on Arrangements, $471. Eli Lilly Co., $100.)	$571.00	
Registration	947.00	
Programs	12.15	
Subsidy American Psychiatric Association	1,200.00	
Total Income—Annual Meeting		13,184.15
Total Income		$61,742.45

EXPENSES

Expenses—General Account:		
Salary—Executive Assistant	$6,199.92	
Clerical Salaries	4,181.17	
Printing	4,419.30	
Committee Expense	6,224.67	
Joint Committee on Personnel and Mental Hygiene	4,225.00	
Fellowship Certificates	46.25	
Membership Certificates	40.30	
Telephone and Telegrams	732.82	
Electricity	81.24	
Rent	1,952.60	
Postage	1,281.40	
Insurance and Annuities	552.86	
Check Tax	26.73	
Travelling Expenses—Austin M. Davies	37.51	
Foundation Expense	1,999.07	
Office Supplies	326.98	
Old Age Benefit Tax	87.36	
Income Tax—Withholding	128.70	
Miscellaneous	959.14	
Total Expenses—General Account		$33.503.02
Expenses—AMERICAN JOURNAL OF PSYCHIATRY:		
Printing—JOURNAL	$10,813.48	
Other Printing	101.55	
Editorial Assistance	2,055.54	
Rent	300.00	
Medical Publication Bureau		
Advertising Commission	1,522.76	
Printing, Promotional and Mailing	214.35	
Salaries	2,190.33	
Postage	393.50	
Check Tax	4.64	
Mailing Back Numbers	64.54	
Miscellaneous	62.84	
Total Expenses—JOURNAL Account		17,723.53
Expenses—Annual Meeting, Chicago, Ill.		
Commercial Exhibits—(Commission, $1,675.12)	$2,768.65	
Scientific Exhibits	142.75	
Final Program and Postage	1,020.22	
Movies, Slides, Theater, Operators and Screen	482.65	
Cocktail Party	1,024.90	
Badges and Ribbons	180.21	
Travelling Expenses	464.32	
Registration Cards	31.75	
Committee on Public Education	247.18	
Committee on Standards	40.54	
Psychiatric Foundation	1.19	
Committee on Nursing	23.40	
Committee on Program	39.40	
Carried forward	$6,486.56	

Brought forward	$6,486.56	
Council	$328.49	
Honorarium	305.36	
Banquet (Including Orchestra, Menus, Dance, Etc.)	3,213.11	
Tips	109.00	
Reporting	215.14	
Page Boys, Ushers and Watchman	259.70	
Expressage	48.78	
Telephone and Telegrams	66.21	
Ladies Committee	67.45	
Refund Subsidy (Including $500 1944 Annual Meeting)	1,700.00	
Miscellaneous	408.58	
Total Expenses—Annual Meeting		13,188.98
Total Expenses		$64,415.53
Less: Total Income Brought Forward		61,742.45
Excess of Expenses Charged to Surplus		$2,673.08

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS FOR PERIOD APRIL 1, 1946, TO MARCH 31, 1947

Cash Receipts:		
Membership Dues		
Back Dues	$1,969.50	
1948-49	1.00	
1947-48	184.66	
1946-47	28,677.00	
Fellowship Certificates	295.00	
Membership Certificates	66.00	
Biographical Directory	2.75	
Rent—Committee Psychiatric Nursing	700.00	
Rent—AMERICAN JOURNAL OF PSYCHIATRY	300.00	
Interest—Savings Accounts and Bonds	754.70	
Insurance Refund	92.04	
Refund Annual Meeting	1,700.00	
Total Income		$34,742.65
Cash Disbursements:		
Salary—Executive Assistant	$6,199.92	
Clerical Salaries	4,181.17	
Printing (1945-Member List $382.50, 1946-Member List $2,920.63)	4,419.30	
Committee Expense	6,224.67	
Fellowship Certificates	46.25	
Joint Committee for Personnel and Mental Hygiene	4,225.00	
Membership Certificates	40.30	
Telephone and Telegrams	732.82	
Electricity	81.24	
Rent	1,952.60	
Postage	1,281.40	
Insurance and Annuities	552.86	
Check Tax	26.73	
Travelling Expense—Austin M. Davies	37.51	
Foundation Expense	1,999.07	
Office Supplies	326.98	
Old Age Benefit Tax	87.36	
Income Tax—Withholding Account (To Be Refunded)	128.70	
Miscellaneous	959.14	
Total Disbursements		33,503.02
Excess Receipts over Disbursements		$1,239.63
Add: Cash Balance, April 1, 1946		20,859.53
Cash Balance, March 31, 1947		$22,099.16

Journal Account

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS FOR PERIOD APRIL 1, 1946, TO MARCH 31, 1947

Cash Receipts:		
Subscriptions	$7,919.76	
Advertising	5,527.52	
Back Numbers	290.28	
Miscellaneous—Reprints, Etc.	78.09	
Total Cash Receipts		$13,815.65
Disbursements:		
Printing (Vol. 102, No. 5-Vol. 103, No. 2—4 issues)	$10,813.48	
Other Printing	101.55	
Editorial Assistance		
Volume 102, No. 5 to Volume 103, No. 4	1,031.23	
Miss Lavell—Salary	808.38	
Miss Lavell—Travelling	115.93	
Rent—Office	100.00	
Medical Publication Bureau		
Commission—Vol. 102, No. 5-Vol. 103, No. 3	1,522.76	
Advertising Expense	214.35	
Rent	300.00	
Salaries		
Eva Borduk—6 Months	1,250.04	
Jean Strenkert—6 Months	940.29	
Postage	393.50	
Check Tax	4.64	
Mailing Back Numbers	64.54	
Miscellaneous	62.84	
		17,723.53
Excess Disbursements over Receipts		3,907.88
Add: Cash Balance March 31, 1946		6,472.88
Cash Balance March 31, 1947		$2,565.00

SCHEDULE OF CASH AND RESOURCES, MARCH 31, 1947

	Book Number	Balance
Chase National Bank	.....	$2,685.05
Union Dime Savings Bank	1,115,778	4,718.63
Emigrant Industrial Savings Bank	137,048	4,733.60
Bowery Savings Bank	258,266	5,036.97
Manhattan Savings Bank	3,557	4,924.91
Total Cash Balance		$22,099.16

Net Resources

American Psychiatric Association (As Above)	$22,099.16
U. S. Government Defense Bonds	15,000.00
Canadian Government Bonds	3,057.00
AMERICAN JOURNAL OF PSYCHIATRY—Chase National Bank	2,565.00
Meeting Account as Per Statement as of October 28, 1946	26.52
Net Resources Available	$42,747.68

Reconciliation of Surplus Account

Surplus, April 1, 1946	$45,420.76
Less: Excess Disbursements over Income for the Year	2,673.08
Surplus April 1, 1947	42,747.68

ANALYSIS OF COMMITTEE EXPENSES, MARCH 31, 1947

	Total	Clerical	Travelling and Meetings	Telephone Postage and Printing	General
Executive	$2,453.79	$120.00	$1,801.52	$178.40	$353.87
Membership	438.13	.....	368.29	69.84	.....
Public Education	70.00	.....	.....	.....	70.00
Program	735.13	61.41	611.57	62.15	.....
Reorganization (Special)	1,066.19	.....	790.58	275.61	.....
Standards and Policies	280.80	.....	280.80	.....	.....
Nursing (Psychiatry)	16.99	10.00	.....	4.84	2.15
Clinical (Psychology)	174.66	.....	174.66	.....	.....
Nominating	275.13	.....	43.45	231.68	.....
Psychology of Childhood	13.03	.....	.....	13.03	.....
Medical Education	557.19	.....	517.79	39.40	.....
Arrangements	2.10	.....	.....	.....	2.10
Preventive Psychiatry	109.17	.....	109.17	.....	.....
Military Psychiatry	12.97	.....	.....	12.97	.....
Forensic Psychiatry	19.39	.....	.....	19.39	.....
Total	$6,224.67	$191.41	$4,697.83	$907.31	$428.12

COMMITTEE ON PSYCHIATRIC NURSING—ROCKEFELLER FOUNDATION SPECIAL FUND

Statement of Cash Receipts and Disbursements
For Period April 1, 1946, to March 31, 1947

Receipts:		
Grant—Rockefeller Fund		$12,404.88
Disbursements:		
Salary—L. Anderson	$4,675.00	
Salary—A. Loos	1,764.96	
Clerical Assistants	25.00	
Travelling—L. Anderson	906.64	
Printing	155.41	
Telephone and Telegrams	195.28	
Office Supplies	396.14	
Postage	169.06	
Advisory Committee Expense	642.06	
Social Security Tax	41.89	
Rent	700.00	
Miscellaneous Expense	168.54	
		9,839.98
Excess of Income over Disbursements for Period		$2,564.90
Add: Cash Balance, April 1, 1946		151.28
Cash Balance, March 31, 1947		$2,716.18

PRESIDENT HAMILTON.—This report is presented to you from our auditors based on the audit by Frederick Parsons, certified public accountant.

On motion by Dr. Stevenson, seconded by Dr. Pace, it was voted to accept and approve the report.

PRESIDENT HAMILTON.—I might explain something to you about the composition of the Council during the forthcoming year. It will consist again of fifteen members. We have a separate secretary and treasurer now, but there will be one vacancy. Dr. Menninger becomes president-elect and it is impossible to fill his vacancy. There has been presented to you this morning a notice of an amendment to the constitution which will prevent vacancies of that sort in the future. We have referred the matter to Council and there is no way in which for this year we can fill the vacancy since Dr. Menninger was already a councillor. We think, however, that the Association has done well with fifteen councillors for at least twenty years and it will do just as well in the forthcoming year.

The meeting was adjourned at 10.10 a.m.

Friday Morning Session

May 23, 1947

The business session of the American Psychiatric Association convened at 9.00 o'clock in the South Penn Top of the Hotel Pennsylvania, Dr. Samuel W. Hamilton presiding.

President Hamilton.—The meeting will come to order.

The first order of business is the report on resolutions from the Committee on Resolutions, Dr. Steckel, Chairman. The report will be presented by Dr. McNeil:

Dr. McNeil.—As is customary at the annual meetings of this Association, the Committee on Resolutions reports as follows:

"Be It Resolved, That the Association be complimented for the outstanding success of this, the 103rd annual meeting, which has broken all records for attendance.

"There have been 1,546 members and fellows in attendance, and the total registration, as of Thursday, May 22nd, including ladies and guests, was 3,297.

"Be It Resolved, That the Association record its indebtedness to its President, Dr. Samuel W. Hamilton, his masterful leadership and able guidance during an unusually difficult year. His devotion to duty has been an inspiration to all of us and has meant much to all of those who have been actively associated with him in the management of the affairs of the Association. His comprehensive address requires special mention and his vision for the future of the organization bespeaks a capacity for prophesy such as few of us possess; and to Dr. Winfred Overholser, President-Elect, and to Dr. Leo H. Bartemeier, Secretary-Treasurer, and to the Council and Chairmen and members of the various committees the Association owes deep appreciation for their collaboration, which has resulted in one of the most successful years of our organization.

"Be It Resolved, That commendation be expressed to Dr. William Malamud and to the members of his Program Committee for the manner in which the program was organized and for the interesting papers presented and topics discussed.

"Be It Resolved, That the Association record its appreciation to Dr. Frederick W. Parsons, Chairman, and to Dr. C. Charles Burlingame, Vice-Chairman, and their associates on the Committee on Arrangements for the efficient manner in which they discharged their duties, making it possible for thorough enjoyment of the hospitality of a great city to all those in attendance.

"Be It Resolved, That special mention be made of and gratitude expressed to Mrs. Robert B. McGraw, Chairman, and her associates on the Women's Arrangement Committee, for the exceptional program of entertainment provided for the wives and lady guests of the Association.

"Be It Resolved, That special appreciation be expressed to Dr. Clarence B. Farrar, Editor of our Journal, who has unstintingly devoted much time without remuneration to the end that our publication has attained outstanding recognition in its field.

"Be It Resolved, That the gratitude of the Association be expressed to Mr. Austin M. Davies, its Executive Assistant, and his office staff for their efficient service rendered throughout the past year.

"Be It Further Resolved, That deep appreciation be expressed to Mr. Pierre S. du Pont, to Dr. Arthur H. Ruggles, and to Dr. William C. Menninger for their outstanding contribution to the successful program of The Psychiatric Foundation on Wednesday afternoon.

"Be It Resolved, That this Association draw the attention of the governors and legislative bodies of our various states to the present competition which exists between the state institutions on the one hand and the Veterans Administration and other organizations on the other, with special reference to the personnel—medical, nursing, and ward—of our mental hospitals and—

"Be It Further Resolved, That this Association earnestly recommends that immediate steps be taken to remedy this condition so that the standard of care in our state mental hospitals be maintained at the highest possible level.

"Be It Resolved, That the thanks of the Association be tendered the management of this hotel for the excellence of the general arrangements, which has contributed so much to the comfort and enjoyment of our members and guests.

Respectfully submitted,

H. A. Steckel, M. D., *Chairman*
Carl J. Hedin, M. D.
Edwin E. McNiel, M. D.
Charles G. Stogdill, M. D.
Charles A. Zeller, M. D."

President Hamilton.—You have heard the report of the Committee on Resolutions. What has been said about the President is somewhat exaggerated, for his address did not go into predictions. However, what was said about the officers and the committeemen is more than justified.

Dr. Zabriskie moved the acceptance of the report. Dr. Bartemeier seconded the motion, and it was so voted.

President Hamilton.—The order of business now calls for the introduction of the President-Elect. Aside from this being the customary form of procedure, one hardly needs introduce a man who is more widely known than any but a few of the psychiatrists in this country.

Dr. Overholser has been called upon to participate in the proceedings of many scientific organizations. I see his name on the programs of the American Association for the Advancement of Science, and on various organizations' programs. Not only is he appreciated in such societies and in more popular gatherings, but he is also known, and his services in demand, in the ecclesiastical world, as most of you probably know.

To him I turn over this gavel as a symbol of the confidence that you have placed in him for the coming year, and we know that his knowledge, his experience, his wide acquaintance, and his fairness and judgment will cause the business of the Association to be done not only with order and dispatch but also with an appreciation of all the various currents of thought that enter into our activities.

In token of this, sir, if you will rise, I formally hand to you, Dr. Overholser, the gavel of the American Psychiatric Association. Dr. Overholser will hand it back. I am not leaving these responsibilities until this afternoon, but it falls on him to wield it for the next year.

DR. OVERHOLSER.—Thank you, Dr. Hamilton.

Colleagues, Friends: I appreciate deeply, it is needless to say, the honor that you have done here in electing me President of this organization. It is an honor and it is a responsibility.

We are the oldest national medical organization in the United States. At the rate we are growing, we shall soon be one of the largest. We live in a time of change. Some of you have indicated there is an interest in modifying the manner in which the organization is conducted, and during the coming year, the Council will certainly consider seriously the possible ways of implementing any changes which seem to be called for in the face of changing needs.

There has been some talk of making the organization more democratic. I sometimes wonder, myself, whether perhaps it is not already becoming too big to be truly democratic rather than representative. It may well be that we need to have an entire change in the method of the representation of the members. However, that is simply one of the things which we have to consider and shall consider.

Once again I thank you. I assure you that I shall do everything in my power to see that the organization is run according to the wishes of the majority of the membership.

I have one official act to perform at this time before I hand the gavel back to Dr. Hamilton. I am sure that Dr. Hamilton, with his becoming and characteristic modesty, felt that perhaps the words of the Resolutions Committee were somewhat exaggerated. Those who know him do not think that they were exaggerated. He has shown during the past year—a particularly difficult year for everyone in many ways, and also particularly difficult in this Association—a fairness, an ability to try to see both sides of problems, and to point them out with good humor, with a friendly spirit. He has shown that although years bring wisdom, they do not necessarily cause sclerosis of the faculty to adjust to changing situations. It is my very pleasant privilege at this time to pin upon Dr. Hamilton's ample bosom the Past President's badge. Will you kindly rise, Dr. Hamilton?

This is, to me, merely a token of the pleasure I have had, Dr. Hamilton, in working with you. Many thanks to you on behalf of the Association.

DR. HAMILTON.—I thank you. I prize this. It was an honor that I did not expect a few years ago, and it has been a pleasure to deserve as much of it as possible. Now that I join the ranks of the distinguished persons on the top shelf, I will endeavor to see that this badge of former service is in sight at as many of our meetings as can be.

The incoming officers of the sections will be given to you by the Secretary.

DR. BARTEMEIER.—The officers of the sections for the coming year are as follows:

Section on Private Practice
Chairman, Wendell Muncie, Baltimore
Secretary, J. G. N. Cushing, Baltimore

Section on Convulsive Disorders
Chairman, H. Houston Merritt, New York City
Secretary, Willard W. Dickerson, Caro, Michigan

Section on Forensic Psychiatry
Chairman, George M. Lott, Long Island
Vice-Chairman, Richard L. Jenkins, Urbana, Illinois
Secretary, William H. Haines, Chicago

Section on Psychoanalysis
Chairman, Gregory Zilboorg, New York City
Chairman-Elect, Dexter M. Bullard, Rockville, Maryland
Secretary, Lawrence S. Kubie, New York City

Section on Child Psychiatry
Chairman, William S. Langford, New York City
Vice-Chairman, Mabel Ross, Buffalo, N. Y.
Secretary, Oscar J. Raeder, Boston

Section on Military Psychiatry
Chairman, Malcolm J. Farrell, Waverly, Massachusetts
Secretary, Norman Q. Brill, Washington, D. C.

DR. HAMILTON.—I convey to the Committee on Resolutions the thanks of the Association. They saw to it that we thanked everybody else, but they left themselves out.

Any of the Councillors or the representatives of the affiliated societies who are not already informed will please be informed that we meet this noon, twelve o'clock, in Parlor "A" for the last meeting of the Council with its present constitution.

I am reminded that the old Councillors have not all gone home and we will be more than delighted if they will come in and give us their advice. I expect before the day is over to announce the appointment of the members of the Committee for the Lester N. Hofheimer award. That will be given out at the Council meeting.

The question having been raised as to whether there will be another general business session, we leave it to you. Unless it is called for, we will not attempt to have another business session. However, the proceedings of this Council will be brought forward to the next convention. Generally speaking, I find that the members of the Association are generally trustful as regards the Council and,

having themselves elected the Council, they may well be trustful.

You may be interested in some statistics. The number of members and fellows registered is now 1,626; the number of nonmembers, 1,951, making a total of 3,577. Of course you will recognize that this figure is much in excess of any registration we have had before. The largest previous registration was at a Philadelphia convention, where we ran well over two thousand. You may recall that at Chicago we had more of our membership present than we had at Philadelphia, but our membership continues to grow. That is fine; it is magnificent, but as has already been said to you, it creates some problems in organization which I am confident the new Council will be able to meet adequately.

Possible changes in the Constitution may be in order. We have never viewed it as something fixed and immovable. We do change it from time to time, and it can be changed still more.

This is a relatively small attendance, but every one of you has twenty friends to whom you talk about the meeting. Please ask them to be very frank in forwarding to the Secretary of to any Councillor their opinions about changes that should be made; even if those changes are not made overnight, the advice is far from wasted.

The session was adjourned at 9.30 a.m.

LEO H. BARTEMEIER, M. D.,
Secretary.

Minutes of Executive Committee Meetings

September 23, 1946, New York City

Presiding: Dr. Samuel W. Hamilton.

Present: Dr. Leo H. Bartemeier, Dr. Winfred Overholser, Dr. Thomas A. C. Rennie, Dr. Edward A. Strecker, and by invitation, Mr. Austin M. Davies.

(1) In view of the fact that the new Membership Roster will not be available until January, 1947 it was the consensus that a list of the committee members be sent to the Chairmen of all the Committees.

(2) The Committee concurred in sending a list of all living ex-members of Council to the Nominating Committee.

(3) Dr. Bartemeier reported the tentative decisions of the joint meeting of representatives of the Committee on Reorganization and the Committee on Program, held on September 22. The committeemen recommended that the presidential address be given on Monday morning of the next annual meeting; that it follow the addresses of welcome; and that it be followed by one or two addresses of invited speakers, and the name of Surgeon General Thomas Parran was mentioned. The Committee tentatively recommended that the Monday afternoon session be occupied with four separate sessions of scientific presentations. It suggested that Tuesday be devoted to group discussions beginning at 9.00 a.m. and continuing to 7.00 p.m. as recommended in the last report of the Special Committee on Reorganization. Each of these sessions is planned to last not more than two hours. They will be staggered sessions (9.00 to 11.00—10.00 to 12.00—11.00 to 1.00—etc.) and will be presided over by members of our Association who are well qualified to act as Moderators. At each session a member of the Special Committee will speak for 10-15 minutes to open the discussion on the topics concerned.

The Joint Committee further recommended that Wednesday morning be devoted to scientific sessions. It suggested that Wednesday afternoon be devoted to a general meeting on the subject of The Psychiatric Foundation. The Committee recommended that Thursday morning be given to a general meeting for discussing and passing upon the resolutions of the Tuesday meetings. It was planned that Thursday afternoon and all day Friday be given over to scientific sessions.

Dr. Hamilton stated that our Constitution determines that the election of officers will have to take place Tuesday morning and the election of members on Wednesday morning. He discussed the advisability of providing multiple microphones for the meetings of the entire membership so that discussants from various sections of the audience might be clearly heard.

(4) It was voted that the Committee on Psychiatric Standards and Policies be granted a sum not to exceed $500 for travel expenses for a meeting of the Committee.

(5) It was voted to authorize a special committee to confer with the Chicago Branch of the American Civil Liberties Union regarding the constitutional rights of prisoners in connection with the administration of drugs for the purpose of lessening psychological resistances.

(6) Dr. Hamilton advised the Committee that he has seen Mr. Henry Root Stern of the Social Welfare Board of New York State and will talk with him further with regard to his request that a committee of this Association act as advisers in the management of a group of very delinquent boys. The Committee concurred with the advisability of appointing such an advisory committee.

(7) The Missouri Neuropsychiatric Society has filed application to become an affiliate society. They did not include a list of their members and the application was deferred until the next meeting of the Association.

(8) The Executive Committee voted that certain members of the Association who have expressed their intention to resign their membership be informed that the Association will not accept their resignations until their dues are paid.

(9) Dr. Hamilton intends to write the Chairmen of all Committees to obtain abstracts of committee reports for the Executive Committee to digest before the next Council meeting.

(10) The Committee voted (upon motion by Dr. Bartemeier, seconded by Dr. Overholser) to authorize the employment of an additional clerk in the offices of the Association for the preparation of the Biographical Directory at a ceiling of $33 per week.

(11) It was voted (upon motion by Dr. Strecker, seconded by Dr. Rennie) to grant Miss Eve Borduk, who is leaving the employ of the Association, the equivalent of 2 weeks' salary in appreciation of her 7 years' efficient work and loyalty.

(12) The Executive Committee read the report of The Joint Committee on Psychiatric Placement. Dr. Rennie moved and Dr. Overholser seconded that this service be discontinued at the expiration of the present year and that a factual summary of the work of the Committee and information regarding vacancies be published in the Journal. It was voted (upon motion by Dr. Strecker, seconded by Dr. Bartemeier) that the Association pay to the National Committee the salary of Mrs. Ziegler for about 6 months longer, which will amount to approximately $1,000. The Secretary was instructed to notify the National Committee for Mental Hygiene of the above action by the Executive Committee.

(13) It was decided that the next annual meeting of the Association should occupy 5 days beginning on Monday and extending through Friday.

(14) Dr. Strecker moved and Dr. Bartemeier

seconded a motion that the registration fee for attendance by nonmembers be increased to $5 per person and that the registration fee for those in the Armed Forces remain at $1 per person.

(15) The Committee discussed the question of the annual banquet, thought it best to continue this function if prices permit, and hoped that it could be carried out in a more formal manner.

(16) The Committee discussed the place of the 1948 meeting of the Association. Invitations have been received from Kansas City, Missouri, and Portland, Oregon. Dr. Hamilton suggested that the Executive Committee call to the attention of the Council the fact that very few hotels in this country can accommodate all the activities of our annual meeting and that the Council should consider the desirability of meeting in a Convention Hall in order not to retreat from our policy of holding our annual sessions in many parts of the country. The invitation to Portland was seriously considered.

(17) The Committee voted to send copies of the minutes of this meeting to all members of the Council so that they will be well prepared for the discussions at the December meeting.

(18) Dr. Hamilton discussed the advisability of publishing a News Bulletin. It was thought that during the first year The Bulletin should be issued once a month. It was roughly estimated that the editorial cost might be kept down to about $2,500, not including any provision for clerical work. The Committee agreed to recommend to the Council to consider the publication of a monthly News Letter at a subscription of $2 per year, the first copy being sent gratis. It is hoped that additional data with regard to this new venture of the Association will be available by the time of the Council meeting in December.

(19) Dr. Hamilton pointed out that our Constitution does not provide for the immediate replacement of any of our officers in the event of death or resignation. The Committee discussed this problem and will ask the Council to consider it.

(20) Dr. Bartemeier informed the Committee that the Board of Directors of The Psychiatric Foundation will send a letter and pamphlet to each member of our Association explaining the aims and objectives of The Foundation and asking each member to make some donation, however small, prior to a program of wide-spread publicity. The American Neurological Association has endorsed The Psychiatric Foundation and its members will be contacted in the same way as the members of our own Association. The need for securing the approval of the American Medical Association as quickly as possible was discussed.

(21) Mr. Davies read a request from Dr. Henze of the Sandoz Chemical Works requesting reprints of a paper by Dr. Kozol. This question was referred to the Committee on Ethics for an opinion.

(22) Mr. Davies read a letter from Dean Langmuir regarding the estate of Lester N. Hofheimer, which has set aside the sum of $24,000 to be paid to the American Psychiatric Association to provide for the award of 12 successive annual prizes of $2,000 each by the Association, which are to be known as The Lester N. Hofheimer Prizes. Dr. Strecker moved that this gift be accepted after the President and Secretary have concluded satisfactory negotiations.

(23) Mr. Davies read a letter from Dr. Charles A. Brown of the New York Regional Office of the Veterans Administration regarding audio-visual aids. Dr. Tarumianz and Dr. Burlingame do not think this problem comes within the scope of their respective committees and our Association has no committee at the present time to deal with this subject. The Veterans Administration wishes to have some cooperative relationship which will have the endorsement of the American Psychiatric Association. This problem was discussed and Dr. Hamilton will explore it further.

The meeting was adjourned at 12.45 p.m.

February 13, 1947, New York City

Presiding: Dr. Samuel W. Hamilton.

Present: Dr. Leo H. Bartemeier, Dr. Winfred Overholser, Dr. Thomas A. C. Rennie, Dr. Edward A. Strecker, and by invitation, Dr. Frederick W. Parsons and Mr. Austin M. Davies.

(1) The Committee discussed and approved the proposed establishment of the Eastern State Psychiatric Institute in Philadelphia and the creation of a Department of Mental Health for the State of Pennsylvania. The Psychiatric Institute is to consist of 5 units with a bed capacity for 50 patients in each unit, which will be under the direction of the Departments of Psychiatry of 5 Philadelphia medical schools. The program of this Institute will include training of physicians in psychiatry, teaching of undergraduate medical students, and psychiatric treatment of patients.

Dr. Overholser moved that the Secretary be instructed to write to the Governor of Pennsylvania urging, on behalf of the Association, that the establishment of the Eastern State Psychiatric Institute at Philadelphia be expedited. Dr. Rennie seconded the motion, which was passed.

(2) Dr. Hamilton read a letter from Dr. Farrar asking for a decision by the Executive Committee regarding the publication of two committee reports from the Group for the Advancement of Psychiatry. Following a general discussion, Dr. Bartemeier moved that the Executive Committee recommend to the editor of the JOURNAL that these and subsequent reports from the Group for the Advancement of Psychiatry be published in the JOURNAL. The motion was passed, with Dr. Hamilton and Dr. Overholser voting in the negative.

(3) Dr. Parsons, as Chairman of the Committee on Arrangements for the coming meeting of the Association, reported for his Committee which recommends: (A) A cocktail party Monday evening, May 19, for members, (B) The Committee on Arrangements had discussed a dinner meeting for Wednesday evening, May 21, at considerable length, had come to no final conclusions and wished suggestions from the Executive Committee. Dr. Overholser moved that on Wednesday evening, May 21, there be a dinner, followed by the induction of new

Members and Fellows, with music for dancing to follow. Dr. Rennie seconded this motion, which was passed.

Dr. Hamilton reported the names of those on the Committee on Arrangements as follows:

Dr. C. Charles Burlingame, Vice-Chairman and Chairman of the Sub-Committee on Publicity.
Dr. Clarence O. Cheney, Chairman of the Sub-Committee on Finances.
Dr. Robert B. McCraw, Chairman of the Sub-Committee on Hotels and Transportation.
Dr. S. Bernard Wortis, Chairman of the Sub-Committee on Scientific Exhibits.
Mrs. Robert B. McGraw, Chairman of the Ladies Committee.

(4) Mr. Davies reported that The Lord Baltimore Press finds it necessary to increase the cost of publication of the JOURNAL by 20%. A letter from The Lord Baltimore Press indicates the necessity of a decision within 2 weeks regarding the purchasing of paper for future use. Mr. Davies pointed out that the subscription cost to members of the JOURNAL had not been raised although the cost of printing has been increased 40% within recent years. Mr. Davies discussed the advisability of publishing the JOURNAL on a monthly basis.

Dr. Overholser made a motion that Mr. Davies be authorized to make the necessary arrangements to establish the publication of the JOURNAL on a monthly basis beginning with the July, 1947, issue. This motion was seconded by Dr. Rennie and passed.

Dr. Overholser moved that Mr. Davies be authorized to enter into a contract with The Lord Baltimore Press for the 20% increase in the cost of publication of the JOURNAL. Dr. Rennie seconded the motion, which was passed.

Dr. Overholser moved that the editor of the JOURNAL be authorized to make any changes in the style of the cover of the JOURNAL beginning with the July, 1947, issue. Dr Rennie seconded the motion, which was passed.

Dr. Bartemeier moved that the subscription rate be increased to ten dollars beginning with the next volume, but for interns and medical students, five dollars per year. Dr. Strecker seconded the motion, which was passed.[1]

(5) Dr. Hamilton read a letter from the American Medical Association regarding its policy about furnishing reprints to industrial concerns.

(6) Following a general discussion, the Secretary was instructed to send the recommendations of the Nominating Committee to the members of the Association by mail.

Mr. Davies was authorized to have 3,000 ballots printed for the election of officers, which will take place on Tuesday, May 20.

On Motion by Dr. Bartemeier, seconded by Dr. Rennie, the Executive Committee voted that the polls be open from 9.00 a.m. to 4.00 p.m. to provide for voting by all the Members and Fellows attending the meeting. Dr. Hamilton reported that he intended to appoint a number of Tellers to facilitate the casting of ballots at the election of officers during the coming meeting. Dr. Hamilton requested Mr. Davies to inquire regarding the cost of renting a voting machine.

(7) Following some discussion, Dr. Strecker moved that the meeting dates for the 1948 meeting be June 13 to June 18, inclusive. This motion was seconded by Dr. Bartemeier, and was passed.

(8) Dr. Hamilton reported that he had appointed Dr. George K. Pratt and Dr. LeRoy M. A. Maeder to the task of publishing the Newsbulletin, and he read a letter from Dr. Pratt regarding his activities in this connection.

There was a general discussion regarding the Newsbulletin, and Dr. Hamilton instructed the Secretary to write to the affiliate societies asking them to designate correspondents for the Newsbulletin.

It was decided that there should be a monthly issue of the Newsbulletin for at least the first year and that it should contain up-to-date news regarding the membership of our Association. It was hoped that the first issue might appear before the time of the coming annual meeting. The Committee recommended that the Bulletin be printed and distributed by The Lord Baltimore Press. It was thought that the name of this bulletin would be "American Psychiatric Association Newsbulletin."

(9) Dr. Hamilton spoke of the need of developing a Committee on Finances and of the advisability of having the auditors meet together prior to the coming annual meeting, to decide upon a fiscal policy for the Association.

(10) Dr. Hamilton reported that the Sub-Committee on Psychiatry and Industry of the Committee on Public Education has been established as a separate committee. Dr. Leonard E. Himler has accepted the Chairmanship of this committee.

Dr. Thomas M. French is the new Chairman of the Committee on Research.

Dr. Hamilton also read a letter from Dr. William Leavitt, who represented the Association at a meeting of the Social Hygiene Association.

(11) Dr. Bartemeier read a letter from Dr. G. Kirby Collier expressing the hope that some arrangement might be made whereby the members of the American League Against Epilepsy might attend certain sessions of the scientific program during the coming meeting of the Association without the necessity of paying a registration fee. It was concluded that Dr. Collier's request would create future difficulties by establishing a precedent for the admission of other groups without the payment of the customary registration fee.

APRIL 22, 1947, WASHINGTON, D. C.

Presiding: Dr. Samuel W. Hamilton.

Present: Dr. Leo H. Bartemeier, Dr. Winfred Overholser, Dr. Thomas A. Rennie, and Mr. Austin M. Davies, by invitation.

Absent: Dr. Edward A. Strecker.

Dr. Hamilton called the meeting to order at 8.00 p.m.

[1] It was later decided that the rate for medical students and interns should remain at $3.00.

The question of the meeting on Thursday morning, May 22, during the annual meeting, was first discussed. It was moved by Dr. Bartemeier and seconded by Dr. Rennie that the Executive Committee recommend to the Council that in this meeting the membership should act as a Committee of the Whole. The motion was passed.

It was moved by Dr. Overholser and seconded by Dr. Bartemeier that Brigadier Rees be invited to make an address following the banquet Wednesday evening, May 21. The motion was passed.

It was moved by Dr. Rennie and seconded by Dr. Bartemeier that there be a meeting of the Council beginning Saturday, May 17, at 2.00 p.m. This motion was passed.

Dr. Hamilton read a report by Dr. George S. Stevenson regarding the meeting of the United Nations Economic and Social Council.

Dr. Rennie moved, and Dr. Overholser seconded, that a Budget Committee be established, to be composed of the Treasurer of the Association and a few of the former Secretaries. This motion was passed.

It was moved, seconded, and passed, that the salaries of two of the office staff be increased, effective May 1, 1947, Miss Ryder's salary by $200 per year and Miss Phelps', by $500 per year.

Dr. Bartemeier recommended that $12,000 now in the Treasury be invested in U. S. Government bonds to be held by the Association as a Treasury reserve. There was general agreement to this recommendation.

After some discussion, it was requested that the Council be asked to reconsider the advisability of publishing the Newsbulletin.

It was pointed out that the JOURNAL will be operating at an annual deficit of $5,300. It was moved, seconded, and passed, that one dollar be appropriated to the JOURNAL from the dues of each member of the Association.

Mr. Davies reported on the number of meetings held by each committee during the past fiscal year and the amount each committee had spent in connection with these meetings. These data will be published in the JOURNAL.

The meeting was adjourned at 10.30 p.m.

LEO H. BARTEMEIER, M. D.,
Secretary.

CORRESPONDENCE

NEEDS OF THE PUBLIC LIBRARY OF CORFU

A letter received from Mr. Michael Mantoudis, Director of Letters, Theatres, and Cinemas in the Ministry of National Education of the Kingdom of Greece encloses the following letter from the Director of the Public Library of Corfu. Mr. Mantoudis points out that "the historic town of Corfu has always been a great center of Hellenism and the English language is very widely used there."

Contributions that readers of the JOURNAL may wish to make to the Library of Corfu, either of copies of their own publications or otherwise, will be most welcome.

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Owing to the air-raid of the town of Corfu, on Sept. 14, 1943, the Public Library of Corfu has been destroyed. The Library building, together with the various installations and over 70,000 books, most of which were very rare and extremely difficult to replace, was burned and completely destroyed.

The reconstruction and reestablishment of this Library began immediately after the liberation of the Country, chiefly by contributions from Greek and some foreign scientific institutions as well as with the assistance of the Greek Ministry of National Education.

Believing that you are interested in helping scientific institutions of the Allied Countries which have suffered so much the brutality of the enemy attacks, we would ask you to kindly help us in our effort to reorganise this Library, by sending us your publications for it.

Your contribution for the rapid reconstruction of this Library, which is the oldest historical Library of Corfu, will support general Greek culture and will be greatly appreciated.

CONST. SOLDATOS,
Director of the Public Library of Corfu.

THE HEIRENS REPORT

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: In the article appearing in the AMERICAN JOURNAL OF PSYCHIATRY, **104**: 113, 1947, entitled, "A Study of William Heirens" by Foster Kennedy, Harry R. Hoffman, William H. Haines, there appears on page 113 an inaccurate statement. This reads as follows:

"Another interview was arranged and he was examined the same night by Drs. Roy R. Grinker and William H. Haines at which time a conclusion was reached that he was malingering."

This statement is inaccurate because it only corresponds to the opinion at that time of Dr. William Haines. I myself stated that the patient was to some extent consciously malingering but that he was psychotic and that I would so testify if called into court. The data available for study and the report of the prison psychiatrist subsequent to Heirens' conviction all increase my conviction that he was, and still is, psychotic.

ROY R. GRINKER, M. D.

FINLAND NEEDS SCIENTIFIC BOOKS

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Finland has an excellent and keenly scientific minded Technical Institute, Teknillinen Korkeakoulu. During the war its library was bombed and totally destroyed.

On my recent trip to Finland for the American Friends Service Committee, I discussed the situation with Dr. Martti Levon, Director of the Institute. He said he would welcome gifts of scientific and technical books and periodicals from America to take the place of those destroyed. In the remarkable efforts for recovery that the Finns are making, the lack of technical library facilities is a very serious handicap. It would be a practical act of friendship to a nation that holds America in high regard if Americans should contribute good technical books and periodicals to this library.

Any such gifts should be marked for the Institute of Technology, Helsinki, and sent to the Legation of Finland, 2144 Wyoming Ave., N. W., Washington, D. C. Dr. K. T.

Jutila, the Finnish Minister, will arrange for their being shipped to Finland.

ARTHUR E. MORGAN,
Member, American Friends Service Committee, Yellow Springs, Ohio.

COLOR VISION IN PSYCHOTIC PATIENTS

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: A report from this laboratory entitled "Incidence of Defective Color Vision among Psychotic Patients" will soon appear in the *Archives of Ophthalmology.* Our interest in this subject was aroused by the claim of Kaplan and Lynch (Color Blindness in the Psychoses, Am. J. Psychiatry, 101: 675 1945) that psychotic patients, both male and female, show a high incidence of color blindness. This conclusion by Kaplan and Lynch is at variance with that of Millard and Shakow (A Note on Color Blindness in Some Psychotic Groups, J. Social Psychology, 6: 535, 1935) who found the incidence of color blindness in a psychotic population not to be significantly different from that in a normal population.

Our study confirms that of Millard and Shakow. In our opinion the contrary finding by Kaplan and Lynch was in major part due (a) to poor selection of the color blindness test used by them; (b) to ignorance of the many random errors which are made on this test by nonpsychotic subjects whose color vision is normal by other accepted criteria; and (c) to inadequate criteria on which to diagnose the presence of defective color vision. Lack of control of conditions under which the test was administered may also have been a contributing factor.

LE GRAND H. HARDY, M. D.,
Knapp Memorial Laboratories, College of Physicians and Surgeons of Columbia University.

COMMENT

CLARENCE O. CHENEY

The professional stature of Dr. Cheney is indicated by the training experience he had acquired, the succession of important posts to which he was called, and the confidence reposed by his colleagues in his executive and scientific judgment.

After five years' grounding in pathology at Manhattan State Hospital, he was assistant director of the New York State Psychiatric Institute, five years; assistant superintendent of the Utica State Hospital, four years; superintendent of the Hudson River State Hospital, five years; director of the New York State Psychiatric Institute and Hospital, five years; and medical director of the New York Hospital, Westchester Division at White Plains, ten years. He served as consultant to many other hospitals and agencies, including the Veterans Administration and the National Committee for Mental Hygiene. He was on the teaching staff of four medical schools, including the professorship of psychiatry at Columbia University and the professorship of clinical psychiatry at Cornell Medical School. He had been honored by the award of the Columbia University Medal and the Congressional Selective Service Medal. In 1935-1936 he was president of the American Psychiatric Association.

But in this place it is especially as associate on the editorial board of the AMERICAN JOURNAL OF PSYCHIATRY that we speak of him. Dr. Cheney was a senior editor of the board of editors, having been invited to join the staff in 1931. During all these years, and despite the many demands upon his time, not only has he assisted materially with the actual editorial work but he has always been ready to give careful consideration to questions of policy and procedure that arise from time to time and to offer his wise counsel. We have never been wrong in relying upon his judgment.

The casual reader may not be conscious of the multifarious details and often the nice issues involved in the production of a scientific periodical publication. It is by no means a one-man job. It can be carried forward satisfactorily only through the staunch collaboration of such men as Dr. Cheney. And such editorial associates become more valuable as their years on the board increase. This is an added reason why the passing of Dr. Cheney entails a loss that is particularly heavy, a loss keenly felt by his immediate colleagues; but also, although a little less directly, by all the readers of the JOURNAL. The JOURNAL salutes the memory of Dr. Cheney and deeply regrets that he can no longer be called upon for his friendly help.

C. B. F.

NOTICE

Dr. Douglas Thom, chairman of the Nominating Committee of the American Psychiatric Association, reports that, as of December 1, approximately 40 percent of the Members and Fellows of the Association have returned their ballot suggestions. All members were mailed ballots on October 24, and it is hoped that many more ballots will be sent in. If you have not done so, please DO IT NOW.

NEWS AND NOTES

INTERNATIONAL CONGRESS ON MENTAL HEALTH. Preparations for the International Congress on Mental Health to be held in London, England, August 16-21, 1948, are rapidly being developed. As has been previously intimated, this will be a multi professional assembly, and it is expected that a great many countries will be represented. It is the privilege of all psychiatrists and other interested persons to have some part in the planning of the Conference through the formation of local preparatory commissions for discussion of such aspects of mental health as may most interest them. The main presentations at the Conference will originate from these commissions. So far as the American Psychiatric Association is concerned, each member who is so inclined is requested to call together a group of from 3 to 15 persons, so that several fields in the social sciences will be represented. It is also suggested that each mental hygiene hospital medical staff, with its associated psychologists and social workers, might become a preparatory commission. Preparatory commissions are requested to hold meetings at least once a month. Each commission is asked to submit a list of the names and professions of its members and the name and address of the permanent chairman, along with a statement of the problem on which the group is working. Four copies of list and statement should be prepared, one to be sent to Nina Ridenour, Executive Officer, International Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.; one to the Programme Secretary, International Congress on Mental Health, 19 Manchester Street, London W. 1, England; one to the regional chairman; and one to the area coordinator. For the United States, names of regional chairmen will be found in a bulletin entitled "U. S. Participation in the International Congress on Mental Health." Names of area coordinators can be obtained from the Regional Chairmen. Anyone who is interested in forming a Commission should have a copy of the Bulletin. Copies have already been sent to all members of the American Psychiatric Association, and additional copies are available from the office of the International Committee. Commissions will be asked to send in a preliminary report in January and a further report at the end of March.

The reports of the preparatory Commissions emanating from all the countries concerned in the Congress are to be studied by a preliminary conference to be held in London for 3 weeks during July, 1948, at which time the main reports, indicating the areas of agreement and disagreement and problems for future study, will be drafted for presentation to the International Congress in August.

The main theme of the Congress is "Mental Health and World Citizenship." Preparatory commissions are asked to keep this general theme in mind in deciding on the particular phase they may discuss, and it has been suggested that the American contribution focus on problems of the mental health of children and how they may be influenced by war and international tensions. It is hoped constructive policies will emerge from the International Congress. Each preparatory commission, however, should consider itself entirely free to select any topic which may be even remotely or indirectly related to the main theme of the Congress.

It is proposed that the International Committee for Mental Hygiene will be replaced by a new organization to be set up, tentatively to be known as the World Federation for Mental Health. It is expected that this body will be truly international and will contain members representing all the social sciences, and that this will be the international body for dealing with mental health problems in relationship to the World Health Organization and UNESCO.

Dr. Frank Fremont-Smith, medical director of the Josiah Macy, Jr., Foundation is vice-president for the United States of the Interim Governing Board, and has recently returned from England where he has conferred with the president, Dr. J. R. Rees, and others who are undertaking the actual organization of the Congress.

DIAGNOSTIC CENTER TO BE ESTABLISHED IN NEW JERSEY.—New Jersey is planning to establish a Diagnostic Center, an institution for the screening of various types of cases prior to institutionalization or other disposition. One of the largest groups of cases will be those referred by the courts for determination of mental status and recommendations prior to sentence. Another group will be cases referred by the mental hygiene clinics for more intensive study than is possible in the community. Other cases may be referred by practicing physicians, hospitals, etc. The institution will be ready to function on an outpatient status sometime during the latter part of 1948. It is hoped that an inpatient service of 150-200 beds will be functioning during the course of 1949.

Facilities will include all forms of psychiatric and psychological examinations and testing. There will also be electroencephalographic and pneumoencephalographic examinations and other forms of specialized studies. Research and individual investigation will be encouraged. The staff will include qualified psychiatric social workers, psychologists, and psychiatrists, all working under a Director.

Candidates for the position of Director are now being considered by the Commissioner of the Department of Institutions and Agencies. A qualified psychiatrist with administrative ability and an interest in forensic psychiatry is desired for the position. The salary will depend on experience and qualifications but will probably be between $7,500 and $10,000. Any interested persons may write to Dr. Henry A. Cotten, Jr., Deputy Commissioner, Department of Institutions and Agencies, State of New Jersey, Trenton 7.

JACKSONVILLE STATE HOSPITAL OBSERVES CENTENNIAL.—Observance by the Department of Public Welfare of the 100th anniversary of the establishment of Illinois' first institution for the mentally ill was held in Jacksonville, Illinois, on July 27, 1947, in conjunction with a meeting of the Third Division of the American Legion.

The celebration included a banquet for members of the Third Division, attended by nearly 500 guests and held in the dining room of the veterans' unit of the hospital. Dr. Winfred Overholser, President of The American Psychiatric Association and superintendent of St. Elizabeths Hospital, Washington, D. C., gave the principal address, entitled "Jacksonville, 1847—Psychiatry Then and Now," in which he paid tribute to Illinois for its program in the care and treatment of the mentally ill. The history of the hospital was described by Governor Dwight H. Green in an address on "Illinois—the Humanitarian," delivered by Richard Yates Rowe, Treasurer of the state of Illinois.

On the second day of the festivities, a colorful parade of the Third Division, other veterans' organizations, and representatives of the Jacksonville Chamber of Commerce passed from the public square to the hospital grounds, where a program was presented to the guests, who included members of medical societies, nurses' associations, patriotic societies, and civilians. The group was welcomed by Dr. James L. Smith, superintendent of the hospital. Dr. Harry R. Hoffman, state alienist, was chairman of the program committee.

DR. BURLINGAME HONORED BY FRENCH GOVERNMENT.—At a dinner at the Union Club in New York City, Sept. 10, 1947, in honor of Dr. Justin Godart as representative of the French Government, Dr. C. Charles Burlingame was formally given the decoration of an officer of the French Legion of Honor in recognition of his services to international health and welfare. This decoration represents a promotion, Dr. Burlingame having been for several years a Knight of the French Legion of Honor. He has also been the recipient of other special honors from France and other countries.

THIRD CONGRESS ON GENERAL SEMANTICS.—The Third Congress on General Semantics will be held in 1948 under the auspices of the University of Denver. Tentative dates are August 13, 14, and 15. Workers in general semantics and allied fields are invited to contribute papers and progress reports on applications of the discipline. A preliminary announcement and information

about attendance at the Congress will be available early in 1948 from Dr. Elwood Murray, Chairman of the Congress Committee, University of Denver, Denver, Colorado.

DR. GLUECK HEADS NEW CLINIC.—Dr. Bernard Glueck has temporarily taken over the directorship of a newly established psychiatric consultation center in Glens Falls, N. Y. This organization is sponsored by the Mental Hygiene Association and the Community Chest of Glens Falls and is located at 360 Glen St. The Medical Society of Glens Falls and other social agencies are interested in the project and lending their cooperation.

Dr. Glueck was enabled to undertake this new work by reason of the fact that Dr. Bernard Glueck, Jr., on his return from the Army took over the management of Stony Lodge Sanitarium, which Dr. Glueck, Sr., had directed for many years.

RESIDENCY TRAINING IN RICHMOND, VIRGINIA, VA HOSPITAL.—The Council on Medical Education and Hospitals of the American Medical Association has given its temporary approval to the residency training in psychiatry offered by the VA Hospital at Richmond, Virginia. The training program is of 3 years' duration. All phases of psychoses and psychoneuroses and a great variety of neurological and neurosurgical cases can be found in this 1,000-bed hospital. The Neuropsychiatric Service, which is headed by Dr. Benedict Nagler, has still some vacancies for residents. Interested physicians should apply to the Subcommittee on Psychiatry, Dr. R. Finley Gayle, Jr., Chairman, Medical College of Virginia, Richmond, Virginia.

MICHIGAN SOCIETY OF NEUROLOGY AND PSYCHIATRY.—The Society's first meeting of the year, September 11, 1947, was held jointly with the Michigan Society for Mental Hygiene and the Cornelian Corner, with Dr. J. Clark Moloney presiding. Dr. David Levy, of New York, presented a paper entitled "Maternal Overprotection." The formal discussant was Dr. Harry A. August.

The second meeting of the year was held at the Traverse City State Hospital, October 30, 1947. At this meeting also, a scientific program was presented, with several contributions.

Officers of the Society are Dr. J. Clark Moloney, President; Dr. Ralph M. Patterson, President-Elect; Dr. Ivan C. Berlien, Secretary-Treasurer; and Dr. Roscoe W. Cavell, Dr. Thomas J. Heldt, and Dr. Louis S. Lipschutz, Councilors.

WASHINGTON SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY.—After a number of preliminary meetings, dating back to May 15, 1946, the first formal meeting of the Washington Society for the Advancement of Psychotherapy (no connection with any other organization) took place on January 16, 1947. The object of the society is to advance knowledge in the field of psychotherapy. It proposes to do this by joining together all the workers in psychotherapy, not limiting its scope to any one school of therapy, and by discussions, lectures, institutes, publications, and other forms of dissemination of knowledge and experience.

Membership in the organization is at present limited mainly to three groups of physicians: (1) active membership is limited to physicians who are psychiatrists, have had a minimum of 10 years of actual experience in psychotherapy, have been recognized as having achieved an unquestioned reputation in psychotherapy, and who, at the time of the application for and during their membership, devote their entire time to the clinical practice of psychotherapy; and (2) associate membership limited to (a) psychiatrists who are in various degrees of training, (b) physicians in general practice.

On June 6, 1947, the Society was incorporated under the laws of the District of Columbia. The officers of the Society are as follows: President, Louis S. London, M. D.; Vice President, Leopold E. Wexberg, M. D.; Executive Director and Secretary, Benjamin Karpman, M. D.; Treasurer, Philip Litvin, M. D. At the same time the Washington Institute for Psychotherapy was organized and incorporated.

CENTRAL NEUROPSYCHIATRIC ASSOCIATION MEETING.—The twenty-third annual

convention of the Central Neuropsychiatric Association was held in Galveston, Texas, October 17-18, 1947. This organization was formed in 1922 with the idea of affording better mutual acquaintanceship among the neurologists and psychiatrists of the central and western states and provinces. At each annual meeting, the members in the convention city demonstrate their clinical and research activities and facilities.

Dr. Titus H. Harris arranged the all-Texas program, including contributors from Austin, Dallas, Fort Worth, Houston, San Antonio, and Waco.

Officers for the coming year are as follows: President, Dr. William C. Menninger; Vice-President, Dr. Walter L. Bruetsch; Secretary-Treasurer, Dr. Lee M. Eaton; and Counselor, Dr. Clarence E. Van Epps.

GROUP THERAPY SESSIONS IN NEW YORK.—Announcement has been received of two series of group therapy meetings which will be held under the direction of Dr. George Lawton, attending psychologist, Psychiatry Department, Vanderbilt Clinic, New York. The series are designed for men and women from 35 to 60 years of age and for those over 60. Difficulties of adjustment on the part of each participant will be considered by all. The groups will meet twice weekly for five weeks; membership in each will not exceed ten. The meetings will last about 75 minutes and will take place in Dr. Lawton's office, 41 West 82d St., beginning November 18. Each series will be repeated in March and in May, 1948.

MOOSEHAVEN: CITY FOR THE AGED.—The Loyal Order of Moose, which established the well-known Mooseheart Laboratory for Child Research 17 years ago, now extends its support of research to the old age group. The Fraternity announces the appointment of a National Advisory Council for Research in Gerontology for the Fraternity's city for the aged at Moosehaven, near Jacksonville, Florida. It is hoped to make Moosehaven a model for the country in the care of the aged, and also to establish there a department of research available to all. Interested scientists should address inquiries to Dr. Martin L. Reymert, Mooseheart, Illinois.

NEW VOLUME ON OLD QUILTS BY DR. DUNTON.—Contingent to his pioneer work in occupational therapy and as a hobby of long standing, Dr. William Rush Dunton, Jr., has collected a vast deal of information concerning old quilts. Much of this information covering the past 100 years is presented in a new, privately printed volume of nearly 300 pages and profusely illustrated. Information concerning this new work can be obtained by writing directly to Dr. Dunton, 33 No. Symington Road, Catonsville, Md.

CORRECTION TO CERTIFICATIONS BY AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY.—The name of Dr. Henry S. Colony, Lt. Comdr. (MC), USN, was omitted from the list of those certified at Philadelphia, May 15-17, 1947.

BOOK REVIEWS

INTRODUCTION TO PSYCHOBIOLOGY AND PSYCHIATRY. (Second Edition, 1946). By *Esther Loring Richards, Sc.D.* St. Louis: C. V. Mosby Company, 1946.

It is stated that the book is for students of nursing and medicine, but it is obviously designed primarily as a text book in psychiatry for nurses. The whole field of psychiatry is surveyed. The book is divided into three parts: Part One—Fundamentals of Human Behavior Functioning; Part Two—Fundamentals of Psychiatric Work; Part Three—Fundamentals of Psychiatric Illnesses and General Treatment Procedures, and finally an appendix. The concepts that are formulated are those of Adolf Meyer, and the author makes it quite clear that this is her approach to the subject. As such it can be recommended as a simple, clearly written exposition of Adolf Meyer's views. The level at which the book is written is obviously for those without any special information or training in the field. The material presented gives some of the fundamental concepts of psychiatry based on the psychobiological viewpoint. The chapter on alcoholism is contributed by Dr. Robert Seliger and is in accordance with the generally accepted views on this subject. There are a few minor errors which one is surprised to see get by in a second edition of the book. The Dark Ages are stated as starting in the fourth century B. C. It is stated, "The intelligence test was given to us by Binet and Simon in 1911," and that insulin treatment "found vogue in this country in our State hospitals in the early 1930's." In discussing electric shock it is stated "since this treatment can be done in a few minutes in contrast to insulin and metrazol." These are examples of minor errors which do not seriously detract from the over-all presentation, which is on the whole an excellent one. The book can be recommended for its purpose, which is primarily as a text book in psychiatry for nurses.

KARL M. BOWMAN,
Langley Porter Clinic,
San Francisco, Calif.

RORSCHACH PSYCHOLOGY. By *Paul Maslow.* (Brooklyn: Brooklyn College Press, 1945 (multigraphed).)

In this manuscript, the author presents some philosophical viewpoints, derived by him out of Rorschach test language. How tenuous is his foundation for the theorizing, he himself tells us (p. 110): "Incidentally, the additions made to the Rorschach technique in this book have not been validated in an approved scientific fashion. Theories arising from and checked against a few individuals (biased and poor observers of themselves) and the speculative correlations between the specific aspects of the personality and the Rorschach symbols rather than the customary experimentation have been our method. There has been a dependence upon the logical consequences of our basic assumption which enabled us to draw what we considered to be the most probable conclusions. Our belief in the validity of these conclusions is strong because the basic theory consists of a number of independent strands that came together from various directions to support our whole concept of personality. But though our basic theory has not been proven right, neither has it been proven wrong . . . . in the meantime, the only real 'proof' we have to offer is our own satisfaction with the results to date."

A further index to his approach is seen in his bibliography. Out of 104 titles, this reviewer identifies 12 as Rorschach papers; 3 as larger volumes that include Rorschach test reports. The other references are distributed within (a) the general literature of psychology and psychiatry; and (b) heavy concentration on writings represented by Whitehead, Spinoza, Reid, Collingwood, Cohen, Plato, and other thinkers in this range.

The level of the publication is exemplified in such obfuscations as (p. 12): "PM thought (opinion) is based upon movements which the individual directs as he pleases as compared to AM thought (understanding) which is controlled by the animal seen in the response and EM thought (reason) which is controlled by the human seen." Another gem (p. 13): "The differentiation of movements into extensor living, inhibited and flexor can also be applied to personal movements. There are EPM, LPM, IPM, and FPM just as there are EM, LM, IM, FM and EAM, LAM, IAM, FAM."

The publication is full of unwarranted statements without any basis in educed evidence. Thus, (p. 83): "Turning the cards (@, ∨, >, <, ∧,) indicates a desire and an initiative to look at all sides of a problem." Again, (p.90): "Those who see emblems on the cards (flags, insignias, signs symbolizing power, prestige, strength, position) look for and fix upon accepted standards in real life as a substitute for personal probing thought and a safe guide for conduct through society."

There are, to be sure, many accurate statements but any Rorschach test student will recognize them as old and common stock of Rorschach test information. What the author thinks he is adding by repeating them, this reviewer is hard put to it to say. In fact, he cannot say why this manuscript has been published at all except as meeting an inner urge for publication.

It all brings to mind a caricature by that prince of caricaturists, Max Beerbohm. In it George Bernard Shaw is represented as attempting to sell some old clothes to the literary critic, Georg Brandes, who is represented as a tailor. The dialogue:

GEORG BRANDES (*'Chand d'Idées*): "What'll you take for the lot?"

GEORGE BERNARD SHAW: "Immortality."

GEORG BRANDES: "Come, I've handled these

goods before! Coat, Mr. Schopenhauer's; waistcoat, Mr. Ibsen's; Mr. Nietzche's trousers—"

GEORGE BERNARD SHAW: "Ah, but look at the patches!"

S. J. BECK, PH.D.,
Chicago, Illinois.

PRINCIPLES OF DYNAMIC PSYCHIATRY. By *Jules H. Masserman, M.D.* (Philadelphia: W. B. Saunders Co., 1946.)

This is the first book of a very ambitious series by which an excellent research worker and writer attempts to formulate what he calls "dynamic psychiatry," which appears to be, as one reads the book, a fusion of the points of view of behavioristic, psychoanalytic, and psychobiologic theories, each of which is very briefly stated and criticized in a total of about 10 pages of the book (pp. 89-98). Such theories as those of Jung, Adler, and other writers are dismissed in about a line and a half. Despite its declared theory of approach, the book struggles between what is essentially a Pavlovian experimental approach and psychoanalytic formulations.

Drugs are hardly considered at all except in relationship to some experiments by the author on alcohol, in which he proves that neurotic behavior is favorably influenced by alcohol. Electric shock is mentioned in one or two places as footnotes to something else and, so far as I can see, prefrontal lobotomy does not enter the picture at all.

Many of the clinical examples of this book consist of correlations between simple frustration experiments on animals and the complex human states which are analyzed in the light of these frustration experiments, as if the comparison had adequacy and relevancy, which, in my opinion, they do not since the hugely complicated social scheme of man and the simple setup of the experiments can only be vaguely likened to one another.

The author establishes 4 principles (p.102) which govern the *biodynamic* theory of behavior, which is his offspring and which he now presents to the world. These are:

"1. *Principle of Motivation.*—Behavior is basically actuated by the physiologic needs of the organism and is directed toward the satisfaction of those needs.

2. *Principle of Experimental Interpretation and Adaptation.*—Behavior is contingent upon, and adaptive to, the organism's *interpretations* of its total milieu, as based on its capacities and previous experiences.

3. *Principle of Deviation and Substitution.*—Behavior patterns become deviated and fragmented under stress, and when further frustrated, tend toward substitutive satisfactions.

4. *Principle of Conflict.*—When in a given milieu two or more motivations come into conflict in the sense that their accustomed consummatory patterns become incompatible, kinetic tension (anxiety) mounts and behavior becomes hesitant, vacillating, erratic, and poorly adaptive (neurotic) or excessively substitutive, symbolic, and regressive (psychotic)."

These 4 principles are not novel, although they are cogently stated and elaborated, and they by no means exhaust the complexity of human life. They are developed in the book with such other matters as come into consideration. Case histories are given with corollaries. Thus, Principle 3 has five corollaries, and the other principles have relevant corollaries of their own.

When the author takes up the criticisms of the biodynamic theory of behavior, he discusses them under the head of *shibboleths.* Apparently anybody who criticizes his work is given to shibboleths, which is not the scientific way to meet objections to the principles which make up his "biodynamics."

The last part of the book is given up to an illustrative analysis of a neurotic personality. Masserman may give homage to Pavlov by his experiments, but in general, although he declares his differences from Freud, he uses his technique, and this illustrative analysis does not differ very greatly from that which has been used from the early days of Freud.

It is a very good thing that at the end of the book Masserman has a glossary of psychiatric terms. The language in which this book is couched is quite formidable, as for example, "From an economic standpoint, therefore, the patient's various symptoms—vomiting, diarrhea and urinary urgency—served as channels for an autoplastic discharge through the eliminative functions of various guilt-ridden aggressive or erotic impulses which the patient, because of covert fear, was inhibited from expressing in alloplastic social behavior" (p. 198). This is a sample of the author's style.

However, we are promised that this is only the beginning of a new point of view called biodynamics; that the next volume will initiate us into the mysteries of compulsive, schizophrenic, and manic-depressive behavior; and that there is being born via this volume a new approach to the problems of psychiatry, which will unify all behavior from the amoeba to man and include the points of view of all the sciences, as well as all the departments of medicine, in one grand explanation and technique. Dr. Masserman is a very learned man, a fine experimentalist, and all things are possible to such a combination of qualities plus great energy and industry. Somewhat skeptical as I am, I wish him well in this, an ambitious and brilliant enterprise.

ABRAHAM MYERSON, M.D.,
Boston.

THE 1946 YEAR BOOK OF NEUROLOGY, PSYCHIATRY AND NEUROSURGERY: Neurology, edited by *Hans H. Reese, M.D.*, and *Mabel G. Masten, M.D.* Psychiatry, edited by *Nolan D. C. Lewis, M.D.* Neurosurgery, edited by *Percival Bailey, M.D.* (Chicago: The Year Book Publishers, 1947).

The scope of the Year Book has been altered again this year and includes neurosurgery in place of endocrinology. The latter, which had been included with neurology and psychiatry since 1934, has been combined with contributions on metabo-

lism and nutrition (removed from general medicine); and these three now constitute a new volume in the Year Book series.

The section on neurology reviews new studies on cerebral localization and fibre tracts, and indicates also the gaps in our knowledge of structural relations. Literature dealing with the anatomy, physiology, and pathology of the central nervous system is summarized in the first few pages. Next follows a subdivision on the convulsive disorders. Each of these two subdivisions is preceded by a brief general statement by the editors, a sort of "argument" which helpfully sums up the main issues. Disorders of the central nervous system, together with diagnostic procedures, arranged under the same subheadings as last year, make up the major portion of this section of the Year Book.

In their introduction the editors remark incidentally (with a wink at the psychiatrists) that "the neurologist's point of view of disease is not clothed in involved or circuitous theorizing with jargon description."

Nolan Lewis' definition of psychiatry as "the study of human adaptation" indicates strikingly the long way traveled and the changes in emphasis and viewpoint since "textbooks of mental diseases" were written. But even until now, as Lewis points out, there has been a comparative neglect of psychiatry in medical education, as became evident during the recent war by the failure of many medical officers to deal suitably with the problems of mental health arising in the armed forces.

The grouping of topics in the psychiatric section suggests the obsolescence of traditional nosological concepts. The organic, toxic, and psychosomatic disorders are separately headlined and quite comprehensively covered. There is also a section for general topics and one on child psychiatry. The remaining psychiatric conditions are treated under the heading, "schizophrenic reactions and other psychoses."

The editor stresses the failure of any and all methods hitherto available for dealing satisfactorily with the problem of crime. "Society should insist on the establishment of research institutes for the investigation of this whole situation, which constitutes a danger to normal societal integration as well as a financial drain on the taxpayers."

The newer therapies widely used in recent years, and also the still lively field of military psychiatry, are fairly represented in the reviews provided.

In his introduction to the new section on neurosurgery, which appears for the first time as a separate section in the Year Book series, Percival Bailey sums up concisely recent advances in this field, particularly the newer methods of treatment coming into use during and since the war. One hundred sixty-five of the 700 pages of text are devoted to neurosurgery, which, as Bailey remarks, "threatens to engulf and extinguish neurology to the detriment of both."

The editor of this section appears to be not altogether comfortable in the company in which he finds himself. With regard to psychiatry, his next-door neighbor in the present Year Book, he has expressed himself rather strongly in another connection (J. Assoc. Am. Med. Colleges, Sept., 1946), where he makes the arresting statement: "Neurology has everything to gain by strengthening her ties with neurosurgery, since both rest on the same intellectual discipline, and by divorcing herself from psychiatry, at least for an indefinite future period, since psychiatry has moved into pathways alien to her genius."

Psychiatry surely needs the closest possible affiliation with neurology and neurosurgery as well as with other branches of medicine, and cannot thrive otherwise. Whatever his specific criticism may be, the opinion quoted above, from a scientist of such distinction as Dr. Bailey, deserves serious consideration.

C. B. F.

PSYCHIATRIC INTERVIEWS WITH CHILDREN. By *Helen Leland Witmer*. (New York: The Commonwealth Fund, 1946.)

Psychiatric Interviews with Children, edited by Miss Witmer at the request of the Commonwealth Fund, is intended for students and practitioners in child psychiatry. It presents detailed records of 10 children treated in child guidance clinics by 8 experienced therapists representing various current schools of dynamic psychiatry. The editor's aim is to demonstrate the methods now in use for the direct treatment of children with emotional difficulties. She also wishes to "analyze the reasoning underlying the therapists' activities in much more detail than has been usual in the literature." In both of these aims she succeeds remarkably well.

The book is divided into two sections. The first consists of a brief history of the development of child guidance clinics, a description of the "teamwork" principle of these clinics, and a discussion of the manner in which therapists utilize the physician-patient relationship for the benefit of the child.

Part Two contains 10 detailed case presentations. The first 3 are the recorded interviews of nonneurotic children; the next 4 are those of children with neurotic symptoms; and the last 3 are of seriously neurotic children. The therapist in each presentation first gives an introductory discussion of the dynamics involved in the child's disorder. He then reports on the activities and conversation of each interview, using elaborate concurrent footnotes for a discussion of the reasoning behind his efforts. The reader thus has a picture of how the therapist interprets and how he reacts to the patient's activities at each stage of therapy. Social Service summaries, furnishing information as to the parents' concommitant progress with the social worker, are inserted frequently among the patient's interviews. Each child presented had at least one parent with whom he felt relatively secure and who also came to the clinic for help.

Because this volume contains so many footnotes it is slow reading. The effectiveness of the therapy varies, as some of the therapists are rather obviously more skilled than others. The divergent points of view regarding behavior motivations pre-

sented here make the responses of some therapists seem more reasonable than others, depending on the reader's viewpoint. By any standard, Dr. Frederick Allen's handling of Betty Ann Meyer seemed to the reviewer a particularly vivid example of sensitive, understanding therapy.

This work has much to contribute to anyone interested in the direct treatment of emotionally disturbed children. The authors are to be complimented on their cooperation in subjecting the details of their techniques to the scrutiny of fellow workers. Beginning therapists will find it helpful in learning how experienced persons in the field react to the minute-by-minute problems of the therapeutic situation.

W. Hugh Missildine, M. D.,
The Children's Psychiatric Clinic,
The Johns Hopkins Hospital,
Baltimore 5, Md.

Textbook of Abnormal Psychology. By *C. Landis* and *M. M. Bolles.* (New York: The Macmillan Company, 1946.)

This textbook has been designed primarily for the use of undergraduate students majoring in psychology, education, sociology, biology, and theology. It will also be of value as an introduction to abnormal psychology for those under training in such professions as teaching, social work, law, and medicine.

The manner in which the material is organized and presented clearly reflects the competence and wide clinical experience of the authors. The senior author is professor of psychology at Columbia University and principal research psychologist at the New York Psychiatric Institute and Hospital. The collaborating author is a former research assistant at the Psychiatric Institute. Both are well known for their original contributions to the research literature in abnormal psychology.

Abnormal psychology is surveyed and the present status of our understanding summarized without undue emphasis on any one particular theoretical interpretation. The viewpoint of the authors is frankly eclectic. Emphasis is given to experimental evidence wherever available.

Three introductory chapters (I-III) deal with the terminology and basic concepts used to describe and classify varieties of human abnormality.

The next 14 chapters (IV-XVII) are devoted to a description of the conventional diagnostic categories commonly used to classify abnormal persons. These include dementia praecox, manic depressive psychosis, neurosis, epilepsy, mental deficiency, disorders of old age, involutional melancholia, alcoholism, general paresis, organc brain disorders, and psychopathic personality. The content of each of these chapters is organized according to the general pattern: introduction, case histories, personal experience, facts and figures, history of the concept, physiology, psychology, summary, and references.

Three chapters (XVIII-XX) are then devoted to a brief but competent summary of the hereditary, cultural, sociological, and developmental factors in etiology.

Six chapters (XXI-XXVI) on psychopathology discuss systematically the disorders of sensation, perception, action, speech, memory, emotion, volition, and intellectual functioning.

The last 8 chapters (XXVII-XXXIV) offer a review of the contributions to our understanding of abnormal persons made by the biological sciences, education, and law.

There is a glossary of the terms used and the book is well indexed. The references listed at the end of each chapter have been carefully selected and are adequate for the beginning student without being overwhelming.

This book is to be recommended as a basic text in abnormal psychology. It is well organized and thoroughly up-to-date in content. The expression is clear and admirably succinct. Of necessity, the book leaves much for the teacher to do by way of amplification and illustration, but unusually adequate coverage of the essential material in the field is provided by the authors.

C. R. Myers, Ph. D.
University of Toronto.

IN MEMORIAM

JAMES S. PLANT, M. D.

1890-1947

The death of Dr. James S. Plant, which occurred in his home in South Orange, New Jersey, on September 7, 1947 of coronary thrombosis, was received with deep regret not only by his professional colleagues, but also by parents, children, and members of other professions.

Dr. Plant was born in Minneapolis, Minnesota, on August 3, 1890. He received his undergraduate training at Hamilton College, from which he graduated in 1912. He received his M.A. from the University of Pennsylvania a year later, and his medical degree from the same University in 1918. In order to prepare himself to practice psychiatry, he studied at the Sorbonne, Paris, for two years, and on his return to this country served as neuropathologist for two years at McLean Hospital, Waverly, Massachusetts. He was assistant director of the Judge Baker Foundation, Boston, from 1922 to 1923, and was director of the Essex County Juvenile Clinic, Newark, New Jersey, from 1923 until the time of his death. In 1938 Hamilton College bestowed on him the honorary degree of Doctor of Science. He was a member of the American Psychological Association, the American Medical Association, a Fellow of the American Psychiatric Association, and a member of a number of state and local medical societies.

Surviving Dr. Plant are his widow, Mrs. Mildred Heller Plant, and two daughters, the Misses Mildred Elizabeth and Harriet Greenleaf Plant.

In addition to a broad and progressive understanding of psychiatry, Dr. Plant brought to his private and professional activities outstanding personality characteristics which made him respected and loved by all who knew him. He had a deep interest not only in his patients, but also in all professional activities that represented growth and advancement in the broad field of psychiatry, a better understanding of psychiatry and mental hygiene by the community, and in working out ways and means of enabling allied professional groups to work together more harmoniously and effectively.

In his pioneering accomplishments, which are many, he was always judicial. He had the capacity to allow others to present their points of view and then give them proper consideration. He was able to "see through the clouds" of confusion, impractical idealization, and static conservation and to clarify discussions to the satisfaction and advantage of all. Perhaps his outstanding quality was his real interest in all people with whom he was associated or with whom he came in contact. Because of this quality, individuals from every station in life who had the good fortune to know him were attracted to him.

In the passing of Dr. Plant psychiatry and mental hygiene have lost one of its outstanding proponents; and his relatives and associates, a real friend.

FRANK J. O'BRIEN, M. D.,
Brooklyn, N. Y.